STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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	F 000		

Survey Date: 2/7/23

Census:71

Sample: 19 + 3 + 2

A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.

During a Standard Survey from 1/27/23 through 2/7/23, the survey team identified the facility failed to activate their emergency response system by calling 911 and immediately initiating Cardiopulmonary Resuscitation (CPR) for a resident who was full-code and found unresponsive and without respirations and a heart rate in accordance with the American Heart Association and the Basic Life Support (BLS) for Healthcare Providers. This deficient practice was identified for 1 of 3 residents reviewed for death in the facility. The facility's failure to call 911 and initiate CPR immediately resulted in the death of Resident #82, which resulted in an Immediate Jeopardy (IJ) situation. The IJ ran from 12/26/22 at 8:40 AM when the resident was found unresponsive and ran until 12/26/22 after in-services of staff began, and the LPN was terminated at 3:00 PM.. The IJ was Past Non-Compliance.

The Past Non-Compliance IJ was identified on 12/26/22 at 8:40 AM which continued until 12/26/22 at 10:04 AM, when paramedics arrived and pronounced the resident dead. The facility

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

Electronically Signed | 02/24/2023

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F 000	Continued From page 1 was back in compliance when they addressed this situation by immediately suspending the Licensed Practical Nurse (LPN) upon an investigation which led to termination, and in-servicing of all staff on emergency situations including CPR; a mock code was performed with all staff; and in-servicing of all agency nurses as scheduled on facility process. The facility's Licensed Nursing Home Administrator was notified of the Past Non-Compliance IJ on 2/1/22 at 3:51 PM.	F 000		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		3/10/23

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F 609	Continued From page 2 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) an allegation of staff to resident neglect that occurred on 12/26/22 when the Licensed Practical Nurse (LPN) failed to call 911 and initiate cardiopulmonary resuscitation (CPR) for a resident (Resident #82) with a full-code status. This deficient practice was identified for 1 of 2 investigations reviewed, and was evidenced by the following: On 2/1/23 at 9:17 AM, the surveyor reviewed the closed medical record for Resident #82 who had expired in the facility. The surveyor reviewed the medical record for Resident #82. A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1 [redacted]). A review of the Admission/Readmission Evaluation dated EX. Order 26.(4) B1 at 12:45 PM, reflected the resident was EX. Order 26.(4) B1 , EX. Order 26.(4) B1 .	F 609	Jersey Shore Post Acute PLAN OF CORRECTION (POC) F609 Annual Survey 2023 Compliance Date: 3/10/2023 How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #82. The Administrator and Director of Nursing were in-serviced on the facilities Incident/Accident investigating and reporting policy which include reporting of alleged violations to the New Jersey Department of Health. ¿ The incident was reported to the New Jersey Department of Health. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents who have an alleged violation of abuse or neglect have the ability to be affected by the facility not meeting the standard of reporting to the New Jersey Department of Health (NJDOH). What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The Administrator & Director of Nursing	

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F 609	Continued From page 3 A review of the Order Summary Report (OSR) included a physician's order (PO) dated [redacted], for full code status. A review of the Progress Notes reflected a Nursing Note (NN) dated [redacted] at 9:08 AM, written by the LPN who indicated the resident expired around 8:45 AM; EX. Order 26.(4) B1 [redacted] disconnected, bathed, and groomed by Nurse and Certified Nursing Aide (CNA). Family member called and explained the situation; Physician called. An additional NN dated [redacted] at 9:10 AM, written by the Infection Preventionist/LPN (IP/LPN) indicated upon entering the building this nurse was called to resident's room; resident was noted with EX. Order 26.(4) B1, 911 was immediately called since resident was a [redacted] A NN dated 12/26/22 at 10:10 AM, written by the IP/LPN indicated paramedics on scene, [redacted] maintained. Resident was pronounced dead by physician [name redacted] at 10:04 AM with family at bedside. On 2/1/23 at 9:33 AM, the surveyor attempted a phone interview with the LPN who did not answer. The surveyor left a message to call back. On 2/1/23 at 9:40 AM, the surveyor interviewed the IP/LPN who stated Resident #82 expired at the facility. The IP/LPN stated she was not in the building when the situation occurred, she walked into the building with the paramedics arriving right after. The IP/LPN continued a family member was in with the resident, so she offered emotional	F 609	were in-serviced on the facilities Incident/Accident investigating and reporting policy which include reporting of alleged violations to the New Jersey Department of Health. ¿ The Director of Nursing /designee or Administrator will audit incidents and accidents to ensure appropriate events are reported to the New Jersey Department of Health, monthly for 3 months then quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The Director of Nursing/designee or Administrator will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits	

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F 609	Continued From page 4	F 609		

support. The LPN, who was an Agency Nurse, was the nurse at the time of the death.

On 2/1/23 at 10:19 AM, the surveyor interviewed the Director of Nursing (DON) who stated Resident #82 was a EX. Order 26.(4) B1 resident at the facility and was very sick with EX. Order 26.(4). The day the resident expired, there was an Agency Nurse (LPN) who was flustered when she went into the resident's room; she tried to get the code status; called the Physician and family member; called 911, but she did not start CPR. The DON stated she obtained a statement from the LPN and conducted an investigation.

On 2/1/23 at 10:35 AM, the DON provided the surveyor with the LPN's statement dated 12/26/22, which indicated the nurse was assigned to the resident that morning. The resident was seen during rounds with their EX. Order 26.(4) B1 EX. Order 26.(4); they took vital signs; preformed mouth care; and administered medication for their blood pressure of EX. Order 26.(4) The resident was alert and did not verbalize any discomfort, no facial grimacing, and breathing unlabored. Around 8:40 AM, the Registered Dietitian (RD) informed her the resident was EX. Order 26.(4) B1 in their bed. The LPN stated she rushed to the resident's room with the CNA and noted the resident was slumped over an non-responsive. The LPN began to "panic" and she shook the resident and took vital signs, but there was no pulse. The LPN asked the CNA to get to the DON, and the CNA informed they were coming. The LPN reported being "so flustered trying to think what to do". The LPN called the Physician and then called the resident's family member. When on the computer, the LPN noticed the resident was a EX. Order 26.(4) B1 and went into "full blown panic mode",

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F 609	Continued From page 5	F 609		

and she went back into the room to start EX. Order 2. The family member was in the room at this time and did not want me to start EX. Order 2. The LPN left the room to give them privacy and saw the Licensed Nursing Home Administrator (LNHA) who asked if 911 was called. The LPN stated "no" and proceeded to call 911.

On 2/1/23 at 1:13 PM, the surveyor interviewed the Medical Director (MD) who stated a full-code status meant the resident wanted everything done; which included calling 911; initiating basic EX. Order 2 or advanced EX. Order 2 with an automated external defibrillator (EX. Order 2 a device used to deliver an EX. Order 26.(4) B1 to the EX. Order 26.(4) B1). The MD stated if the resident was a EX. Order 26.(4) B1 and EX. Order 26.(4) B1 the nurse would immediately call a code and all staff would be helping assist. One staff member would immediately call 911, while another staff would start CPR until the paramedics arrived who would then take over. The MD stated that unless the family member was the medical Power of Attorney (POA), they could not authorize staff to stop CPR.

At this time, the surveyor reviewed the LPN's statement with the MD. The surveyor asked if the LPN should have called the Physician first and then the family member when the resident was non-responsive, the MD replied no, you would call 911 first and initiate EX. Order 2 which were the important part of the code. The MD stated the patient was always first, not notifying the Physician or family, and the nurse should never leave the resident during a code.

On 2/1/23 at 1:58 PM, the surveyor interviewed the DON who confirmed the resident was a

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F 609	Continued From page 6	F 609		

full-code status which meant the resident wanted all treatments to revive them including being sent to the hospital and [redacted]. If the resident was a [redacted] the first thing the nurse would do was call the code and other staff would come. The LPN should never leave the resident, other staff would be delegated to check the code status, call 911, start [redacted] grab the crash cart which contained the [redacted]. The LPN who was [redacted] certified would have continued to perform [redacted] until the paramedics arrived and took over. The DON confirmed the LPN did not call the code, and 911 was not notified immediately, and [redacted] was not initiated immediately or at all. The DON also confirmed the family member was not the POA, so the nurse should have initiated [redacted] despite the family's request not to. The DON stated the facility conducted an investigation to determine why the LPN who was an Agency Nurse did not call the code. The DON stated she informed the LPN's Agency that the facility did not want her back because of her incompetency, but acknowledged she did not notify the NJDOH of the incident and should have.

On 2/2/23 at 10:21 AM, the surveyor re-interviewed the DON who stated she choose to investigate this incident to determine where the system breakdown was because this was basic nursing.

A review of the facility's "Incident/Accident Investigating and Reporting Policy and Procedure" dated updated 2/2022, included...in the event the incident is found to be reportable based on the DOH reportable guidelines, the necessary information will be reported to the DOH in a timely manner.

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F 609	Continued From page 7 NJAC 8:39-9.4(f)	F 609		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to a.) communicate a [redacted] recommendation for a [redacted] treatment to the physician and b.) to follow EX. Order 26.(4) B1 for the administration of a EX. Order 26.(4) B1 medication in accordance with professional standards of practice. This deficient practice was identified for 2 of 24 residents (Resident #66 and #82) reviewed for standards of practice and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	Jersey Shore Post Acute PLAN OF CORRECTION (POC) F658 Annual Survey 2023 Compliance Date: 3/10/2023 How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #66 and Resident #82. Doctor was called and order was obtained and carried out for resident #66. ¿ All Nurses were in-serviced on following physician orders and consultation recommendations to ensure they meet the professional standards of care. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents on [redacted] have the ability to be affected by the facility not communicating a hospice recommendation to the physician ¿ All Residents with EX. Order 26.(4) B1 have	3/10/23

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F 658	Continued From page 8 Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 1/27/23 at 12:00 PM, the surveyor observed Resident #66 lying in bed enjoying a visitor playing a [redacted]. The visitor identified themself as being from hospice. On 1/30/23 at 9:13 AM, the surveyor observed Resident #66 lying in bed positioned upright eating potato chips. Their [redacted] were positioned in two slotted pillows, and they wore non-skid socks on their feet. The resident stated they were on [redacted] care, and someone from [redacted] visited them daily. The surveyor reviewed the medical record for Resident #66. A review of the Admission Record face sheet reflected the resident was admitted to the facility in [redacted] with diagnoses which included [redacted] and [redacted]. A review of the most recent annual Minimum Data Set (MDS), and assessment tool dated [redacted], reflected a brief interview for mental status (BIMS) score of [redacted] which indicated	F 658	the ability to be affected by not following the hold parameters for administration of [redacted] medication in accordance with professional standards of practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ Medication administration policy reviewed and updated. ¿ All Nurses were in-serviced on the importance of communicating a [redacted] recommendation and following hold parameters for administration of a [redacted] medication. ¿ All Nurses were in-serviced on the 24-hour chart check process which includes [redacted] recommendations. ¿ Unit Managers/designee will audit recommendations from [redacted] for follow thru, weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. ¿ Unit Managers/designee will audit hold parameters orders for [redacted] medication for accuracy, weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?)	

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F 658	Continued From page 9 a EX. Order 26.(4) B1. A further review reflected the resident received hospice care. A review of the individualized person-centered care plan reflected a focus area initiated EX. Order 26.(4) for EX. Order 26.(4) care for end stage heart failure. Interventions included to communicate needs to EX. Order 26.(4) to work together to obtain comfort and care for resident; give support and reassurance to resident and family members as needed; hospice to be part of the interdisciplinary care team; and plan of care to be reviewed by the interdisciplinary care team, resident, family, and EX. Order 26.(4) as needed. A review of the Hospice Recommendations included a recommendation dated EX. Order 26.(4) to EXX. Ord EX. Order 26.(4) B1 at EX. Order 26.(4) B1 to EX. Order 26.(4) cleanse EX. Order 26.(4) B1 with EX. Order 26.(4) B1 or EX. Order 26.(4) B1 solution; pat dry; apply EX. Order 26.(4) B1 ointment to EX. Order 26.(4) B1; cover with band aide; change daily for fourteen days. The EX. Order 26.(4) size was EX. Or EX. Order 26.(4) B1 with EX. Order 26.(4) B1 off from the surface of the EX. Order 26.(4) B1) on EX. Order 26.(4) B1 EX. O d of band aide with no drainage or odor. The EX. Order 26.(4) B1 Nurse indicated she made the facility's Licensed Practical Nurse (LPN #1) aware of the order. A review of the Order Summary Report (OSR) did not include this treatment as a physician order. A review of the corresponding EX. Order 26.(4) B1 Treatment Administration Record (TAR) did not reflect the resident received this treatment. On 2/2/23 at 1:17 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA #1)	F 658	¿ The Nursing Supervisor/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits	

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F 658	Continued From page 10	F 658		

who stated the resident was particular with who cared for them and preferred to have care done at 5:00 AM by the 11:00 PM to 7:00 AM aide and by their EX. Order 26.(4) E Aide. CNA #1 stated their EX. Order 26.(4) E Aide came daily and provided care during the day shift.

On 2/2/23 at 1:21 PM, the surveyor observed the resident in bed with their EX. Order 26.(4) E Aide performing personal grooming.

On 2/2/23 at 1:33 PM, the surveyor interviewed the Nursing Supervisor/LPN who stated after a resident was evaluated for EX. Order 26.(4) E care, the nurse called the Physician to receive an order for EX. Order 26.(4) care. The Nursing Supervisor/LPN stated that the EX. Order 26.(4) E Aide came daily Monday through Friday to provide care, and the EX. Order 26.(4) E Nurse came too, but he could not speak to the frequency. The Nursing Supervisor/LPN stated any recommendation the EX. Order 26.(4) E Nurse had, they documented it in the resident's paper medical record and informed the facility's nurse. It was the facility nurse's responsibility to communicate the recommendation with the Physician to obtain a physician order. At this time, the surveyor reviewed with the Nursing Supervisor/LPN the EX. Order 26.(4) E Recommendation from EX. Order 26.(4). The Nursing Supervisor/LPN confirmed LPN #1 was the nurse documented as informed and confirmed that the physician order was not obtained and there was no documentation as to why the Physician would not want to carry out the recommendation. The surveyor requested to observe the resident's EX. Order 26.(4)

On 2/2/23 at 1:46 PM, the surveyor accompanied by another surveyor and the Nursing

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F 658	Continued From page 11	F 658		

Supervisor/LPN went into Resident #66's room to observe the wound. The [redacted] Aide removed the resident's non-skid sock, and the Nursing Supervisor/LPN proceeded to remove a [redacted] aide from the [redacted] The surveyor asked when that band aide was applied, and both the resident and [redacted] Aide stated the [redacted] Nurse applied the [redacted] last week during their visit, but they could not recall the exact day. The resident stated the facility's nurse did not change the band aide daily. The Nursing Supervisor/LPN attempted to locate the [redacted] and he stated it appeared to have healed. The [redacted] Aide confirmed the [redacted] had improved from last week based on the appearance.

On 2/2/23 at 1:58 PM, the surveyor interviewed LPN #1 who stated the resident was on hospice and the [redacted] Aide came daily and the [redacted] Nurse came weekly. LPN #1 stated if the [redacted] Nurse had a recommendation, they would document in the resident's paper medical record and flag the page. LPN #1 stated sometimes the [redacted] Nurse in addition communicated directly with her, but it was her responsibility to daily check the resident's paper medical record. When asked what the process was after receiving a recommendation from hospice, LPN #1 stated she would inform the Nursing Supervisor/LPN because she was new to the facility and was unaware how to input a physician order. LPN #1 stated she had not received a recommendation from [redacted] yet. At this time, the surveyor reviewed the Hospice Recommendation dated [redacted], and LPN #1 denied seeing that recommendation. LPN #1 confirmed she did not administer this treatment to the resident today.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 658	Continued From page 12	F 658		

On 2/3/23 at 2:08 PM, the surveyor interviewed the Director of Nursing (DON) who stated once a resident had a physician order for [redacted] care, the [redacted] Aide and [redacted] Nurse along with the facility staff would care for the resident. The DON stated any recommendations made by the [redacted] Nurse were documented in the resident's paper medical record and flagged for the staff. It was the responsibility of the nurse on duty to review the chart to ensure no new recommendations. Any new recommendations, the nurse would call the Physician to communicate the recommendation and obtain a physician's order if the Physician choose to carry-out the recommendation. The DON confirmed if the Physician did not want to carry-out the recommendation, the nurse had to document in the medical record.

On 2/3/23 at 9:03 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Infection Preventionist, Director of Clinical Services, and survey team acknowledged that the [redacted] Recommendation from [redacted] was not communicated to the Physician in accordance with professional standards of practice.

A review of the facility's [redacted] Program" policy dated reviewed 6/2022, included...when a resident participates in the [redacted] program, a coordinated plan of care between the facility, [redacted] agency and resident/family will be developed and shall include directives for managing [redacted] and other uncomfortable symptoms...the facility and [redacted] will identify the specific services that will be provided by each entity and this information will be communicated in the plan of care; the [redacted] and facility will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

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JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 658	Continued From page 13	F 658		

communicate with each other when any changes are indicated or made to the plan of care...

A review of the facility's undated "Order Transcription" policy included...the 11-7 shift will do a 24 hours chart check to ensure all orders are being carried out properly.

2. On 2/1/23 at 9:17 AM, the surveyor reviewed the closed medical record for Resident #82 who had expired in the facility.

The surveyor reviewed the medical record for Resident #82.

A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1 [redacted]).

A review of the Admission/Readmission Evaluation dated EX. O. Order 26.(4) at 12:45 PM, reflected the resident was EX. Order 26.(4) B1, EX. Order 26.(4) B1 with EX. Order 26.(4) B1.

A review of the OSR included a physician's order (PO) dated EX. Order 26.(4) B1, for EX. Order 26.(4) B1 EX. Order 26.(4) B1 milligram (mg) EX. Order 26.(4) B1; give EX capsule via EX. Order 26.(4) B1 [redacted] medications or liquids) one time a day for EX. Order 26.(4) B1; hold (do not administer) for EX. Order 26.(4) B1 [redacted] or EX. Order 26.(4) B1) EX. Order 26.(4) B1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 658	Continued From page 14	F 658		

A review of the corresponding December 2022 Medication Administration Record (MAR) revealed the 9:00 AM EX. Order 26.(4) B1 dose was administered on EX. Order 26.(4) B1 with a EX. Order 26.(4) B1, which was EX. Order 26.(4) B1 and should have been held.

On 2/6/23 at 11:19 AM, the surveyor interviewed the facility's Consultant Pharmacist (CP) via telephone. When asked if a EX. Order 26.(4) B1 medication order had a parameter to hold for a EX. Order 26.(4) B1 than EX. Orde or a EX. Order 26.(4) B1, and the nurse documented a EX. Order 26.(4) B1 and EX. Order 26.(4) B1 should the nurse have administered the medication? The CP responded if there was a EX. Order 26.(4) B1, the nurse should have held the medication as the Physician instructed to.

On 2/6/23 at 11:55 AM, the surveyor interviewed the DON in presence of the survey team who stated there were EX. Order 26.(4) B1 for EX. Order 26 EX. Order 26.(4) B1 medications because a resident could be at risk for EX. Orde if the EX. Order 26.(4) B1 EX. Order 26.(4) B EX. Order 26.(4) The DON further stated that if a physician's order had EX. Order 26.(4) B1 for either the EX. Order 26.(4) B1 the nurse was expected to hold the medication if the EX. Order 26.(4) B1 was outside the EX. Order 26.(4) B1 At this time, the surveyor reviewed with the resident's EX. Order 26.(4) B1 MAR for the EX. Order 26.(4) B1, and the DON confirmed the nurse should not have administered the medication on EXEX. Order 26.(4) because the resident's EX. Orde was below EX. Or

On 2/6/23 at 12:20 PM, the surveyor interviewed the resident's Physician/Medical Director (MD) via telephone. When asked what the purpose of EX. Orde EX. Order 26.(4) B1 were, the MD responded to manage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 658	Continued From page 15 symptoms; you do not want the resident to be EX. Order 26.(4) B1) or EX. Order 26.(4) B1 The MD stated if the physician's order had a parameter to EX. Order for a EX. Order 26.(4) B1, then the nurse was expected to not administer the medication. The MD stated if the nurse called and informed him that the EX. Order 26.(4) B1 and the EX. Order 26.(4) B1 he would have instructed the nurse to administer the medication. The MD confirmed that the professional standard of practice would be to check the EX. Order 26.(4) B1 and EX. Order the medication as prescribed when necessary. The nurse should not administer the medication outside the EX. Order 26.(4) B1 without calling the Physician for instructions. A review of the facility's "Medication Administration" policy dated reviewed 6/2022, included... EX. Order 26.(4) B1: check EX. Order 26.(4) B1 and/or EX. Order 26.(4) B1 immediately prior to pouring... The policy did not include following physician's order regarding medication hold parameters. NJAC 8:39-11.2(b); 27.1(a)	F 658		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	F 678	Jersey Shore Post Acute	3/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 678	Continued From page 16 pertinent facility documentation, it was determined that the facility failed to activate their emergency response system by calling 911 and immediately initiating EX. Order 26.(4) B1) for 1 of 3 residents reviewed who were EX. Order 26.(4) B1 e and were found unresponsive and without EX. Order 26.(4) B1 and a EX. Order 26.(4) B1 (Resident #82), in accordance with the EX. Order 26.(4) B1 EX. Order 26.(4) B1 and the EX. Order 26.(4) B1 EX. Order 26.(4) B1 for Healthcare Providers. Resident #82 was a EX. Order 26.(4) B1 status and had requested EX. Order 26.(4) B1 treatment despite medical decline. The resident was last seen on EX. Order 26.(4) at 7:58 AM, by the nurse who took vital signs, administered EX. Order 26.(4) B1 medications, and left the resident in stable condition. On 12/26/22 at approximately 8:40 AM, the resident was found unresponsive by the Registered Dietician (RD) who immediately alerted the Licensed Practical Nurse (LPN) who in response had a Certified Nursing Aide (CNA) accompany her to the resident's room. The resident was found EX. Order 26.(4) B1 laying slumped over in bed. The LPN documented she began "to panic and shake [him/her]" and checked vital signs. The LPN later asked the CNA to help reposition the resident. The LPN proceeded to call the Physician and the family member on the telephone. The LPN while on the computer, noticed the resident was a EX. Order 26.(4) B1 status and went into "full blown panic mode, and went back to the room to start EX. Order and the [family member] walked in the room to ask what was doing, and said to stop." The LPN proceeded to not administer EX. Order against the resident's code status request. The LPN left the room and the Licensed Nursing Home Administrator (LNHA) asked if the LPN called 911 in which she	F 678	PLAN OF CORRECTION (POC) F678 Annual Survey 2023 Compliance Date: 3/10/2023 How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #82. ¿ All staff (Nursing, Dietary, Recreation, Therapy, Housekeeping, and Administration) in-serviced on their role and what to do in a code situation. ¿ All staff (Nursing, Dietary, Recreation, Therapy, Housekeeping, and Administration) in-serviced on how to page in an emergency situation. ¿ Mock Code Blue situation was performed in the facility. ¿ Ensure that all nurses hold a current valid EX. Order certification. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents have the ability to be affected by the facility not meeting the requirements of activating their emergency response system by calling 911 and immediately initiating EX. Order 26.(4) B1 where applicable. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ All staff (Nursing, Dietary, Recreation,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

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F 678	Continued From page 17 responded no. According to documentation, the facility never initiated CPR, called 911, or accessed the EX. Order 26.(4) B1 a device used to deliver an EX. Order 26.(4) B1 to the EX. Order 26 to EX. Order 26.(4) B1) in an attempt to provide life-saving measures. Resident #82 was pronounced dead at 10:04 AM, by a physician [name redacted]; cause was an unexpected death. The LPN was terminated from employment at the facility and survey team attempted to reach the nurse multiple times by telephone for an interview and were unsuccessful. There was no documented evidence a "EX. Order 26.(4) B1" (a signal used to communicate an acute medical emergency) was initiated, or that EX. Order 26.(4) B1 was activated upon becoming aware resident was unresponsive. According to NN on 12/EX. Order 26, 911 was not called until 9:10 AM. There was no documented evidence once paramedics arrived that the resident was evaluated for EX. Order 26.(4) B1 or the use of the EX. Order. Interview with the Director of Nursing (DON) on 2/1/23 revealed all nurses were certified in EX. Order, so there was always someone in the facility that could perform EX. Order. The DON provided a copy of the LPN's valid EX. Order 26.(4) B1. The facility's failure to appropriately initiate CPR and the appropriate activation of emergency response (including calling 911) for a resident who was a EX. Order 26.(4) B1 and was found to be unresponsive without a EX. Order 26.(4) B1 and EX. Order 26.(4) B1, placed all residents who were a EEX. Order 26.(4) B1 at risk for imminent death if found to be	F 678	Therapy, Housekeeping, and Administration) are continuously being in-serviced on their role and what to do in a code situation. ¿ All staff (Nursing, Dietary, Recreation, Therapy, Housekeeping, and Administration) are continuously being in-serviced on how to page in an emergency situation. ¿ Mock code blue drills will be conducted on various shifts monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The Director of Nursing/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits	

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	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 678	Continued From page 18	F 678		

EX. Order 26.(4) B1 and without EX. Order 26.(4) B1. This resulted in an Immediate Jeopardy situation.

The Immediate Jeopardy (IJ) began on 12/26/22 at 8:40 AM, when the resident was found unresponsive and ran until 12/26/22 after in-services of staff began, and the LPN was terminated at 3:00 PM. The IJ was Past Non-Compliance.

The facility was notified of the Past Non-Compliance IJ situation on 2/1/23 at 3:51 PM. The facility was back in compliance when they addressed this situation by calling 911; suspending and then terminating the LPN upon investigation; all staff were in-serviced on code-status; when to initiate EX. Order; documentation in an emergency situation and communication with nursing management; performed a mock code; and in-serviced all Agency staff on facility policy.

The evidence was as follows:

Reference: The EX. Order 26.(4) B1 EX. Order 26.(4) B1 guidelines every EX. Order 26.(4) B1 for EX. Order 2 and Emergency EX. Order 26.(4) B1. These guidelines reflect global resuscitation science and treatment recommendations... In the guidelines, AHA has established evidenced-based decision-making guidelines for initiating EX. Order 2 when EX. Order 26.(4) B1 occurs in or out of the hospital. EX. Order urges all potential rescuers to initiate EX. Order unless: 1) a valid EX. Order 26.(4) B1) order is in place; 2) obvious clinical signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or 3)

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	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 678	Continued From page 19	F 678		

initiating [redacted] could cause injury or peril to the rescuer. [redacted] guidelines for [redacted] provide the standard for the EX. Order 26.(4) B1, state EMS agencies, healthcare providers, and the general public.

On 2/1/23 at 9:17 AM, the surveyor reviewed the closed medical record for Resident #82 who had expired in the facility.

A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1 [redacted]

A review of the Admission/Readmission Evaluation dated [redacted] at 12:45 PM, reflected the resident was EX. Order 26.(4) B1, [redacted] with [redacted].

A review of the Order Summary Report (OSR) included a physician's order (PO) dated [redacted] for [redacted] status.

A review of the Progress Notes (PN) for Resident #82 which included the following notes:

A Nursing Note (NN) dated [redacted] at 6:30 AM, written by the resident's 11:00 PM to 7:00 AM shift Registered Nurse (RN), included the resident was toileted three times during this shift; [redacted] done and coverage given as ordered; left comfortable in bed, call bell with-in reach; no signs or symptoms of pain or discomfort noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 678	Continued From page 20	F 678		

A Health Status Note (HSN) dated EX. Order 26.(4) B1 at 9:08 AM, written by the LPN, revealed the resident had expired around 8:45 AM; EX. Order 26.(4) (a EX. Order 26.(4) B1 which can be used to give medications or liquids) disconnected; the resident was bathed and "growned" by nurse and CNA; family member called spoke with [name redacted] explained the situation and he/she hung up the phone; Physician notified.

A NN dated 12/26/22 at 9:10 AM, written by the Infection Preventionist/LPN (IP/LPN), revealed upon entering this building this nurse was called to resident's room; resident was noted with no EX. Order 26.(4) B1 or EX. Order 26.(4) B1 EX. Orde called immediately as resident was a EX. Order 26.(4) B1.

A NN dated 12/26/22 at 10:10 AM, written by the IP/LPN, included paramedics on scene; no blood pressure or heart rate maintained; resident was pronounced by physician [name redacted] at 10:04 AM with family at bedside.

There was no documented evidence that 911 was called at the time the resident was found EX. Order 26.(4) B1 was immediately initiated or initiated at all; or a AED was used.

On 2/1/23 at 9:33 AM, the surveyor attempted to call the LPN on the telephone, a male party answered, the surveyor stated his/her name and the purpose of the call, and the call was disconnected. The surveyor placed the call again, there was no answer, and the surveyor left a message on the voicemail to please return the call as soon as possible. LPN did not return surveyor's call.

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	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 678	Continued From page 21	F 678		

On 2/1/23 at 9:40 AM, the surveyor interviewed the IP/LPN who stated Resident #82 had been admitted to the facility for EX. Order 26.(4) B1 was very EX. Order 26.(and expired at the facility. She further stated she was not in the building when the situation occurred on EX. O. Order 26.(4), she walked into the building with the paramedic arriving right after.

On 2/1/23 at 10:19 AM, the surveyor interviewed the DON who stated she was familiar with Resident #82 that he/she had been at the facility for a EX. Order 26.(4) B1, had EX. Order 26.(4), and was ailing. She further stated the resident had expired at the facility and had been taken care of that day by an Agency Nurse (LPN). The DON stated she had interviewed the LPN who stated she had been flustered and had gone into the room; she tried to get his/her code status; left the room and called the Physician and family member; and then she called 911; she did not start EX. Order 2 When the surveyor asked the DON what the facility's procedure was when you find a resident EX. Order 26.(4) B1 she responded when you find someone EX. Order 26.(4) B1 you should call the EX. Order 2 then call 911. The DON stated she did have a copy of the LPN's witness statement; she conducted an investigation.

On 2/1/23 at 10:35 AM, the DON provided the surveyor with the LPN's statement dated EX. Order 26.(4) B1, which indicated the nurse was assigned to the resident that morning. The resident was seen during rounds with their EX. Order 26.(4) B1 running; they took vital signs; preformed mouth care; and administered medication for their blood pressure of EX. Order 26.(4) The resident was alert and did not verbalize any discomfort, no facial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 678	Continued From page 22	F 678		

grimacing, and breathing unlabored. Around 8:40 AM, the RD informed her the resident was slumped over leaning in their bed. The LPN stated she rushed to the resident's room with the CNA and noted the resident was EX. Order 26.(4) B1 and EX. Order 26.(4) B1. The LPN began to "panic" and she shook the resident and took vital signs, but there was no EX. Order 2. The LPN asked the CNA to get the DON, and the CNA informed them they were coming. The LPN reported being "so flustered trying to think what to do". The LPN called the Physician and then called the resident's family member. When on the computer, the LPN noticed the resident was a EX. Order 26.(4) B1 and went into "full blown panic mode", and she went back into the room to start CPR. The family member was in the room at this time and did not want me to start EX. Order 2. The LPN left the room to give them privacy and saw the LNHA who asked if 911 was called. The LPN stated "no" and proceeded to call 911.

On 2/1/23 at 10:54 AM, the surveyor interviewed the DON in the presence of the survey team. When the surveyor asked where the code status of a resident can be found, the DON replied all residents EX. Order 2 statuses were located in the electronic medical record on the opening screen; as well as a hard copy was included on the physician's orders which were printed monthly and placed in the residents' hard charts. The DON stated the facility also had a backup system for recalling a few hours of information if the electricity or electronic medical record were unavailable. The DON stated that the CNAs had access to residents' EX. Order 2 statuses in their task manager. The DON stated she was not in the building at the time of Resident #82's death, but stated every nurse should know they should call a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 678	Continued From page 23	F 678		

EX. Order 2 EX. Order 2 if the resident was unresponsive and begin if applicable. The DON stated she also thought the problem was the family member told the LPN to stop EX. Order 2 when the LPN tried to initiate it. When asked if the family had the authority to stop the EX. Order 2, the DON stated I do not know.

On 2/1/23 at 11:08 AM, the DON stated the family member was not the Power of Attorney (POA; authority to make decisions on behalf of another) so therefore would not have the authority to cease EX. Order 2

On 2/1/23 at 11:49 AM, the surveyor interviewed the RD in the presence of the survey team. The RD stated she came into Resident #82's room early in the morning, maybe between 8:00 AM and 8:05 AM, and the resident was turned onto his/her EX. Order 26.(4) B1 and EX. Order 26.(4) B1 was on administering EX. Order 26.(4) B1, and the EX. Order 26.(4) appeared to be spilled on the floor. The RD stated she called out the resident's name, he/she did not respond, so she then got the LPN immediately. The LPN went to the room called his/her name, and the RD left the room as the CNA closed the door behind them.

On 2/1/23 at 12:01 PM, the surveyor attempted to interview the CNA via telephone, she did not answer, and surveyor left voicemail to return the call.

On 2/1/23 at 12:22 PM, the surveyor attempted to call the LPN again, surveyor left another message to call back. LPN did not return surveyor's call.

On 2/1/23 at 1:09 PM, the DON provided the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 678	Continued From page 24	F 678		

survey team a copy of the facility's Incident Investigation Summary for Resident #82.

On 2/1/23 at 1:13 PM, the surveyor interviewed resident's Physician and Medical Director (MD) in the presence of the survey team. The MD stated he evaluated the residents and reviewed the medications and other paperwork on admission to the facility, one of those would be code status. If the resident had a Practitioner Orders for Life Sustaining Treatment EX. Order 26.(4) B1 [redacted]) form, it would be reviewed, and he would make a physician's order for the EX. Order 26.(4) B1. The MD stated EX. Order 26.(4) B1 status meant everything should be done, EX. Order started, 911 called and EX. Order 26.(4) B1 EX. Order 26.(4) B1 as well with use of an EX. Order. The MD stated EX. Order should be started immediately if a person had no pulse or respirations, then immediately tell a staff member to call a EX. Order 26 then follow protocol of airway and breathing, and circulation. The staff member would continue EX. Order until paramedics arrived to take over. When asked if a family member could stop EX. Order, the MD replied only if the family member was the medical POA could they authorize staff to stop EX. Order 2 At this time, the surveyor reviewed the LPN's statement with the MD who confirmed 911 and EX. Order 2 should have been first. The MD also stated the patient was always first, not notifying the Physician or family, and the nurse should never leave a resident during a EX. O. Ord.

On 2/1/23 at 1:59 PM, the survey team interviewed the DON, who confirmed Resident #82 was a EX. Order 26.(4) B status which meant the resident wanted all treatments to revive them including being sent to the hospital. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 678	Continued From page 25	F 678		

continued if staff walked into a room and a resident was unresponsive, they must call a [redacted] tell another staff to call 911 because you should never leave the resident alone; start [redacted]; have another staff member grab the crash cart which contained the [redacted] and [redacted] The DON further stated all nurses who worked in the facility were certified in [redacted], so there was always someone in the facility that could administer [redacted], and staff should continue administering [redacted] until paramedics arrive to take over. The DON stated the LPN stated she had been flustered, and confirmed she did not call the [redacted] so 911 was not immediately called and [redacted] was not immediately initiated. The DON also stated the family member did not have the authority to stop [redacted] so the LPN should have initiated it. The DON stated the facility conducted an investigation to determine why the LPN who was an Agency Nurse did not call the [redacted]. The DON stated she informed the LPN's Agency that the facility did not want her back because of her incompetency.

On 2/1/23 at 2:21 PM, the surveyor reviewed LPN's witness statement to the DON who stated disregard the LPN's Progress Note which indicated the resident was expired at 8:45 AM, the resident was pronounced dead at 10:04 AM after the paramedics arrived. The DON confirmed the LPN had not acted in accordance with professional standards of practice in regard to following resident's [redacted] status preference.

On 2/1/23 at 2:41 PM, the survey team interviewed the LNHA who stated he had worked [redacted] and stated while in building, saw the LPN in the hallway outside of Resident #82's room and the LPN made him aware the resident was found unresponsive. The LNHA asked the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 678	Continued From page 26	F 678		

code status which he was told was EX. Ord Order 26.(4) B1, so he asked if the LPN if she called 911. The LNHA stated the LPN stated no and instructed her to call. The LNHA stated as a result of their conversation the LPN called 911, but he did not recall when the paramedics arrived. The LNHA further stated there were no other nurses helping the LPN when he was there.

The facility's failure to ensure the appropriate activation of emergency response for a resident who was a EX. Order 26.(4) B1 status by calling 911 and initiating EX. Order 2 when the resident was found to be EX. Order 26.(4) B1 without a EX. Order 26.(4) B1 and EX. Order 26.(4) B1, placed all residents who were a EX. Or EX. Order 26 at risk for imminent death if found to be EX. Order 26.(4) B1 without a EX. Order 26 and without EX. Order 26.(4) B1

This resulted in an Immediate Jeopardy situation. The IJ was identified on 2/1/23, and the LNHA and DON were notified of the IJ at 3:51 PM. The IJ was a Past Non-Compliance IJ that ran from EX. O Order 26.(4) at 8:40 AM, when Resident #82 was found EX. Order 26.(4) B1 to EX. Order 26.(4) B1 at 10:04 AM, when the paramedics arrived and pronounced the resident dead. The facility was back in compliance when they addressed this situation by immediately suspending the LPN upon investigation which led to her termination; in-servicing of all staff on emergency situations including EX. Order; a mock code performed with all staff; and in-servicing of all Agency nurses as scheduled on facility process. This was verified by the survey team on-site on 2/1/22.

On 2/6/23 at 7:46 AM, the surveyor interviewed the CNA assigned to Resident #82 on EX. Order 26.(4) B1 via telephone. The CNA stated she was in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 678	Continued From page 27	F 678		

another resident's room performing care down the hall and she went into the hallway to retrieve supplies when the LPN called her to come to Resident #82's room. The CNA stated she went into the room and the resident was not responding; the LPN shook him/her; checked the EX. Order 2[illegible], resident's EX. Order 26.(4) B1 and EX. Order 26.(4) B1; and EX. Order 26.(4) B1. The LPN then instructed her to get the DON, who was not in the building, and she immediately returned to the LPN to let her know. The CNA confirmed she did not inform any other staff members; she just did what she was told to do by the LPN. The LPN then instructed her to help "clean-up" the resident. When asked what clean-up meant, the CNA stated the resident was soiled so they changed their incontinent brief and shorts putting the resident in a gown. The CNA stated the resident's EX. Order 26.(4) B1 of his/her EX. Order 26.(4) B1 EX. Order 26.(4) B1 were on the ground as if they EX. Order 26.(4) B1; it did not appear as if the resident [illegible]. The CNA stated that the LPN did not tell her if the resident had a EX. OrEX. Or but stated the resident "did not look alive" to her. The CNA stated she did not recall the LPN calling a EX. Order 26.(4) EXEX. O" and the LPN did not perform C[illegible]. The CNA further stated anyone can call a EX. Order [illegible] that she assumed the nurse did not call the EX. Order because she was already aware of the resident's EX. Order 2[illegible] status. The CNA stated she was EX. Order certified, but also did not initiate EX. Order.

A review of the facility's Incident Investigation Summary included a copy of the LPN's EX. OR certification. The LPN had a EX. Order Adult, child, infant and EX. Order training valid from 5/19/21 until 5/19/23.

A review of the facility provided daily staffing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 678	Continued From page 28 sheet for [EXEX. Order 26.(4)] revealed on the day shift from 7:00 AM until 3:00 PM, there were four nurses assigned to work and eight CNAs assigned to work that day. A review of the facility's "Code Blue or Code Status Process" policy dated effective 5/3/21 and revised 12/27/22, included a "Code Blue" is the standardized signal used to indicate any acute medical emergency (i.e. respiratory distress, reduced function due to arrhythmia, cardiac arrest or status epilepticus). Every individual whose vital signs are not life sustaining or unobtainable is a candidate for resuscitation unless there has been written patient care wishes to withhold treatment and an existing order in place. It is the responsibility of the licensed nurse to check for the status code order...the first responder is the staff member who discovers an unresponsive individual. The will: call for help - call out to other staff members...He or she stays with the individual...Administer assistance to level of their expertise. Verify unresponsive, absence of respirations or absence of pulse and start CPR if trained...The second responder should be a staff member trained in BLS. They will: alert the receptionist to call Code Blue...bring the crash cart to the Code location. The third responder will be responsible for calling 911...monitor and assist with CPR if required... NJAC 8:39-9.6(g)	F 678		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		3/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 695	Continued From page 29 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) assess and educate a resident on self-administration of EX. Order 26.(4) and EX. Order 26.(4) B1; b.) obtain a physician's order for the self-administration of EX. Order 26.(4) and EX. Order 26.(4) B1; c.) care plan for the self-administration of EX. Order 26.(4) and EX. Order 26.(4) B1 EX. Order 26.(4) B1; d.) accurately sign in the Treatment Administration Record for the administration of EX. Order 26.(4); and e.) accurately sign the Medication Administration Record for the administration of a EX. Order 26.(4) B1 in accordance with standards of practice. The deficient practice was identified for 1 of 2 residents reviewed for EEX. Order 26.(4) B1 care (Resident #51), and was evidenced by the following: On 1/27/23 at 10:59 AM, the surveyor observed Resident #51 sitting in their wheelchair at their tray table in their room. The resident was being administered EX. Order 26.(4) B1 EX. Order 26.(4) at a EX. Orde of EX. Order 26.(4) B1. The resident informed the surveyor that he/she administered their own EX. Order 26.(4) B1 which was usually administered at EX. Order 26.(4) B1), but he/she will increase the EX. Order as needed. The resident stated they had EX. Order 26.(4) B1	F 695	Jersey Shore Post Acute PLAN OF CORRECTION (POC) F695 Annual Survey 2023 Compliance Date: 3/10/2023 How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #51. Nurse immediately called the EX. Order 26.(4) B1 and carried out proper recommendation for resident #51 for oxygen administration. ¿ Resident was educated on the importance of following doctor's orders for EX. Order 26.(4) administration. ¿ Self Administration of Medication Assessment of EX. Order 26.(4) B1 was completed for the resident. ¿ The orders regarding self-administration of EX. Order 26.(4) B1 for resident #51 were obtained from the doctor and carried out. ¿ Care plan was entered for residents for self administration of EX. Order 26.(4). ¿ The nurses and nursing managers were in-serviced on the facility procedure for: 1. Educating and assessing the residents for self administration of EX. Order 26.(4) and EX. Order 26.(4) B1.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 695	Continued From page 30 EX. Orderler 26.(4) B1, and he/she had been managing their EX. Order 26.(4) for years. The surveyor also observed EX. Order 26.(4) B1 on the resident's bed, and they informed the surveyor that he/she administered their own EX. Order 26.(4) B1. The resident stated he/she was educated by the facility, and they had all their EEX. Order 26.(4) B1" The surveyor reviewed the medical record for Resident #51. A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses including EX. Order 26.(4) B1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated EXX. Order 26.(4)E reflected that the resident had a brief interview for mental status (BIMS) score of a EX.O out EX.O, which indicated a fully intact cognition. A further review reflected the resident received oxygen while in the facility, and he/she had received EX. Order 26.(4 daily during a seven day look back period. A review of the individualized person-centered care plan included a focus area initiated EX. Order 26.(4) B1 for an as needed order for EX. Order 26.(4 use with regards to EX. Order 26.(4) B1 . Interventions were to administer supplemental EX. Order 26.(4) B1 EX. Order 26.(4) B1 saturation EX. Order 26.(4) B1 of for EX. Order 2 The care plan did not include the resident self-administered their EX. O. Order 26.(4 A further review of the care plan included a focus	F 695	2. Care plans for the self administration EX. Order 26.(4) B1 , 3. Accurately signing the Treatment Administration Record for the administration of EX. Order 26.(4) . 4. Accurately signing the Medication Administration record for the self administration of a EX. Order 26.(4) B1 . How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents that are on EX. Order 26.(4) E or have the ability to self administer their own EX. Order 26.(4) have the ability to be affected by this deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The nurses and nursing managers were in-serviced on the facility procedure for: 1. Educating and assessing the residents for self administration of oxygen and respiratory inhalers. 2. Care plans for the self administration of EX. Order 26.(4 and EX. Order 26.(4) B1 3. Accurately signing the Treatment Administration Record for the administration of EX. Order 26.(4) E 4. Accurately signing the Medication Administration record for the self administration of a respiratory inhaler. ¿ The nursing manager/designee will audit self administration evaluation and education	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 695	Continued From page 31 area initiated EX. OX, Order 26.(4) B1 for EX. Order 26.(. Interventions included to educate resident/family/caregivers regarding side effects and overuse of EX. Order 26.(4) B and EX. Order 26.(4) B1; encourage prompt treatment of any EX. Order 26.(4) B1 infection; and give medications as ordered (i.e. EX. Order 26.(4) B1) monitor/document side effects and effectiveness. The care plan did not include the resident administered their own EX. Order 26.(4) B1 [redacted] OSR) included the following physician's orders (PO) A PO dated EX. Order 26.(4), to administer EX. Order 26.(4) B1 EX. Order 26.(4) B1 every twenty-four hours as needed for EX. Order 26.(4) B1 EX. Order 26.(4) B1 less than EX. Order. A PO dated EX. Order 26.(, for EX. Order 26.(4) B1 EX. Order 26.(4) B1 to EX. Order 26.(4) B1, a EX. Order 26.(4) B1 EX. Order 26.(, administer EX. Order 26.(4) B1 two times a day for EX. Order 26.(4) B1 after each use. A PO dated EX. Order 26.(4) B for EX. Order 26.(4) B1 EX. Order 26.(4) B1, a EX. Order 26.(4) B1, administer EX. Order 26.(4) B1 y one time per day for EX. Order 26.(4); EX. Ord EX. Order 26.(4) B1 of EX. Order 26.(4) B1 in EX. Order 26.(4) B1. Separate each EX. Orde by EX. Order 26.(4) B1 for maximum drug absorption and effect. A PO dated EX. Order 26.(4), for EX. Order 26.(4) B1 EX. Order 26.(4) B1 a EX. Order 26.(4) B1, administer EX. Order 26.(4) B1 orally every four hours as needed for EX. Order 26.(4) B1 well before administration. Wait EX. Order 26.(4) B1 between EX. Order 26. The OSR did not include a PO that the resident could administer their EX. Order 26.(4) B1 EX. Order 26.(4) B themselves.	F 695	assessment in PCC weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. ¿ The nursing manager/designee will audit self administration orders of EX. Order 26.(4) B1 [redacted] to ensure they are properly documented on the Medication Administration record, weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. ¿ The nursing manager /designee will audit the TAR to ensure accurate documentation of oxygen administration weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. ¿ The nursing manager/designee will audit new orders for self administration respiratory inhalers, weekly for 1 month, then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The nursing manager/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits	

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	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 695	Continued From page 32	F 695		

A review of the corresponding EX. Order 26.(4) B1 Medication Administration Record (MAR) reflected the nurse was signing daily for the administration of the EX. Order 26.(4) B1 and EX. Order 26.(4) EX. Order 26.(4) B1. The MAR also included a PO dated EX. Order 26.(4) and discontinued EX. Order 26.(4), for EX. Order 26.(4) B1 to administer EX. Order 26.(4) B1 orally every four hours as needed for EX. Order 26.(4) ; EX. Order 26.(4) before administration. The EX. Order 26.(4) B1 EX. Order 26.(4) was documented as not administered for the month.

A review of the corresponding EX. Order 26.(4) B1 Treatment Administration Record (TAR) reflected the resident did not receive EX. Order 26.(4) for the month.

A review of the corresponding EX. Order 26.(4) B1 MAR reflected the nurse was signing daily for the administration of the EX. Order 26.(4) B1 and EX. Order 26.(4) EX. Order 26.(4) B1 and the as needed EX. Order 26.(4) B1 EX. Order 26.(4) B1 was not administered for the month.

A review of the corresponding EX. Order 26.(4) B1 TAR reflected the resident did not receive EX. Order 26.(4) for the month.

A review of the corresponding EX. Order 26.(4) B1 MAR reflected the nurse was signing daily for the administration of the EX. Order 26.(4) B1 and EX. Order 26.(4) EX. Order 26.(4) B1, and the as needed EX. Order 26.(4) B1 EX. Order 26.(4) B1 was not administered for the month.

A review of the EX. Order 26.(4) B1 3 TAR reflected the resident did not receive EX. Order 26.(4) for the month.

A review of the Physician Progress Notes included a note dated EX. Order 26.(4) B1, that the resident was seen by the EX. Order 26.(4) B1 Nurse Practitioner EX. Order 26.(4) and was observed with EX. Order 26.(4) being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 695	Continued From page 33	F 695		

administered at EX. Order 26.(4) B1. The resident was complaint with the EX. Order 26.(4) B1 and EX. Order 26.(4) B1. The plan was to continue with baseline EX. Order 26.(4) B1, and EX. Order 26.(4) B1

A further review of the Physician Progress Notes included a noted dated EX. Order 26.(4), that the resident was seen by the EX. Order 26.(4) B1 (medical doctor) and was observed with EXEX. Order 26 being administered at EX. Order 26.(4) B1. The resident was compliant with EX. Order 26.(4) B1 and EX. Order 26.(4) B1 and was dependent on EX. Order 26.(4). The plan was to continue Symbicort and EX. Order 26.(4) B1 EX. Order 26.(4) with EX. Order 26.(4) B1 EX. Order 26.(4) B1 as needed.

On 1/30/23 at 9:30 AM, the surveyor observed the resident sitting in their room eating breakfast with EX. Order 26.(4) being administered at EX. Order 26.(4) B1 a EX. Order 26.(4) B1. The resident confirmed he/she set the EX. Order 26.(4) to that level and that he/she reduced the level to EX. Order 2 while sleeping. The resident stated the Physician was aware they administered their own EX. Order 26.(4), that he/she had being doing it for years. The resident also confirmed he/she kept their EX. Order 26.(4) B1 and EX. Order 26.(4) B1 EX. Order 26.(4) B1 EX. Order 26.(4) B and administered themselves because "it was pain waiting for the nurse to get it." The resident stated it had been "forever" since he/she had been administering their own EX. Order 26.(4) B1 medications.

On 1/30/23 at 11:57 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated the resident was very independent and preferred to not have assistance from staff. The CNA stated the resident always had EX. Order 26.(4) on,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 695	Continued From page 34 and that the nurse handled the EX. Order 26.(4) B1 On 1/30/23 at 12:15 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated there were no residents who self-administered medications and there was no medications in any of the residents' rooms. The LPN stated Resident #51 had breathing issues and was on EX. Order 26.(4) B1 which she checked the setting. The LPN reviewed the PO with the surveyor and confirmed the resident received EX. Order 26.(4) B1 which she stated she did not sign for the administration of the EX. Order 26.(4). The LPN also stated they received EX. Order 26.(4) B1, and EX. Order 26.(4) B1 as needed), which she opened her medication cart and located an unopened box of EX. Order 26.(4, an opened box of EX. Order 26.(4) B1 and there was no EX. Order 26.(4) B1 EX. Order which she stated the resident must be out of. On 1/30/23 at 12:31 PM, the surveyor accompanied by the LPN went into Resident #51's room and the LPN confirmed the EX. Order 26.(4) was being administered at EX. Order 26. The LPN questioned the resident why the EX. Order 26.(4) was at EX EX. Orde, and the resident responded he/she turned the EX. Order 26.(4) to that level and both their Primary Care Physician and EX. Order 26.(4) B1 were aware the EX. Order 26.(4) needed to be at that level. The LPN then confirmed the resident had all EX. Order 2 EX. Order 26.(4) B1) in their possession, and the resident stated he/she was aware how to administer their EX. Order 26.(4) B1, they were doing it for a "long time." The LPN turned the resident's EX. Order 26.(4) down to EX. Order 2 and informed the resident she needed to call the Primary Care Physician.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 695	Continued From page 35 Outside the resident's room, the LPN informed the surveyor she had not administered the resident's EX. Order 26.(4) B1 this morning that she was running late with medications, so another nurse administered the resident's medications. The LPN also confirmed the resident did not have a PO to self-administer their own EX. Order 26.(4) B1 or EX. Order 26.(4). On 1/30/23 at 12:40 PM, the surveyor reviewed the MAR for the day which revealed the LPN signed for the administration of the EX. Order 26.(4) and EX. Order 26.(4) B1 that morning. On 1/30/23 at 12:45 PM, the surveyor reviewed the MAR for the day with the LPN who confirmed she signed for the administration of the EX. Order 26.(4 and EX. Order 26.(4) B1 that morning and she did not administer it, so she should not have signed it. At this time, the surveyor and LPN returned to Resident #51's room and the LPN checked the resident's EX. Order 26.(4) B saturation level which was EX. Order. The LPN then asked the resident if he/she administered their EX. Order 26.(4) B1 that morning, and the resident confirmed he/she used the EX. Order 26.(4) B1, and EX. Order 26.(4) B1 that morning. The resident continued he/she administered the EX. Order 26.(4) B1 every EX. Order hours. On 1/30/23 at 12:47 PM, the surveyor interviewed the Nursing Supervisor/LPN who stated the process for self-administration of medications was to first assess the resident to make sure they can administer the medication as ordered. If the resident was able to do that, the nurse called the physician who wrote the order for self-administration. The Nursing Supervisor/LPN	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 695	Continued From page 36	F 695		

confirmed Resident #51 did not have a PO to self-administer their EX. Order 26.(4) B1 EX. Order 26.(4) B1. The Nursing Supervisor/LPN stated the resident should not be touching their own EX. Order 26.(4) B1 and the nurses should have signed for the administration of EX. Order 26.(4). The Nursing Supervisor/LPN also confirmed the resident's PO for EX. Order 26.(4) B1.

On 1/30/23 at 1:04 PM, the surveyor interviewed the Director of Nursing (DON) who stated the process for self-administration of medication was to first assess the resident to determine if they were capable of administering their own medication. If the resident was able to, the nurse called the physician for an order and the care plan was updated to reflect self-administration of a medication. The nurse would follow-up with the resident to ensure they administered the medication as ordered and the nurse would sign the MAR that the medication was verified as received. The DON stated she was just made aware Resident #51 was self-administering their EX. Order 26.(4) B1 and EX. Order 26.(4) n. The DON confirmed there was no assessment or PO for the resident to do that. The DON stated for EX. Order 26.(4), the nurse would turn on the oxygen and the resident would regulate it.

On 1/30/23 at 1:46 PM, the surveyor interviewed the Pulmonologist via telephone who stated Resident #51 was very particular of their care and kept their EX. Order 26.(4) B1 in their room. The EX. Order 26.(4) B1 stated that the resident was on EX. Order 26.(4) B1 she thought at EX. Order 26.(4). The surveyor reviewed the EX. Order 26.(4) B1 note from EX. Order 26.(4) in which she documented the resident was receiving EX. Order 26.(4) B1. The EX. Order 26.(4) B1 stated with the resident's medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 695	Continued From page 37	F 695		

condition, the resident may need at times an increased amount of EX. Order 26.(4) which would not harm the resident. The EX. Order 26.(4) B1 acknowledged the oxygen should be administered to the PO. The EX. Order 26.(4) B1 stated she may have known the resident was administering their own EX. Order 26.(4) B1 because they were "particular", but she could not recall if she wrote an order for self-administration of the EX. Order 26.(4) B1.

On 2/3/23 at 9:03 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Infection Preventionist, Director of Clinical Services, and the survey team acknowledged Resident #51 was self-administering their EX. Order 26.(4) B1 without a PO and the resident was receiving EX. Order 26.(4) B1 which was not being signed for by the nurses on the TAR and the order need to be changed from an as needed to a EX. Order 26.(4) B1 order. The DON also acknowledged the EX. Order 26.(4) order was for EX. Order 26 and not EX. Order 26.(4) B1

A review of the facility's "Self-Administration of Medication" policy dated reviewed 12/2022, included the procedure: evaluate resident using the "Self-Administration of Medication Assessment" form to determine if criteria for participation in self administration is met...resident self-administration of medication shall only be permitted upon written order of the physician; pharmacy shall label the containers with full directions for use including cautionary labels; the resident shall be taught to properly self-administer medications. nurse shall review with residents directions for use, indication for medication and possible side effects of medication...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 695	Continued From page 38 A review of the facility's "[redacted] Administration" policy dated updated 12/2022, included it is the policy and procedure of the [facility] to provide [redacted] to the residents in compliance with their physician order as followed out by their resident's care provider... NJAC 8:39-11.2(b)	F 695		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents	F 712	Jersey Shore Post Acute PLAN OF CORRECTION (POC) F712 Annual Survey 2023 Compliance Date: 3/10/2023	3/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 712	Continued From page 39	F 712		

conducted face-to-face visits and wrote progress notes at least every thirty days. This deficient practice was identified for 4 of 4 residents (Resident #3, #29, #51, and #55) reviewed for physician visits and was evidenced by the following:

1. On 1/27/23 at 10:59 AM, the surveyor observed Resident #51 sitting in their wheelchair at their tray table in their room. The resident was being administered EX. Order 26.(4) B1 used to deliver EX. Order 26.(4) B1) at a rate of EX. Order 26.(4) B1 The resident informed the surveyor that he/she administered their own EX. Order 26.(4) which was usually administered at EX. Order 26.(4) B1), but he/she will increase the EX. Orde as needed. The resident stated they had EX. Order 26.(4) B1 which impacts EX. Order 26.(4) B1), and he/she had been managing their EX. Order 26.(4) for years. The resident stated he/she was educated by the facility, and they had all their EX. Order 26.(4) B1

The surveyor reviewed the medical record for Resident #51.

A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses including EX. Order 26.(4) , EX. Order 26.(4) B1), and personal history of other diseases of the EX. Order 26.(4) B1 .

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4) B1 reflected that the resident had a brief interview for mental status (BIMS) score of a EXEX. Order 26.(4) , which indicated a fully EX. Order 26.(4) B1 . A

How the corrective action will be accomplished for those residents found to be affected by this practice?
¿ Affecting Resident #3, #29, #51 and #55. Administrator contacted the physician.
¿ Physician conducted face-to-face visit and documented a progress note for resident #3, #29, #51, and #55.
¿ Nursing staff was in-serviced on the importance of the primary care physician conducting and documenting a face-to-face visit every 30 days.
¿ Administrator and Medical Director sent out notifications to all attending Doctors reminding them of their required visits.
How the Facility will identify other residents having the potential to be affected by the same deficient practice?
¿ All Residents have the potential to be affected by not having a documented timely visit from their physician as per CMS guidelines.
What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur?
¿ Administrator and Medical Director sending notifications to all attending Doctors reminding them of their required visits per CMS guidelines.
¿ The nursing managers/designee will audit 20 residents progress notes to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 712	Continued From page 40 further review reflected the resident received EX. Order 26.(4) while in the facility, and he/she had received oxygen daily during a seven-day lookback period. A review of the resident's physician visits since EX. Order 26.(4) B1, revealed that the resident was seen monthly until EX. Order 26.(4) B1. There was no further documentation that the resident was seen by his/her primary care Physician since then. On 1/30/23 at 1:43 PM, the surveyor interviewed the Director of Nursing (DON) who stated the Resident #51's Physician conducted all the visits for his residents and he did not have a nurse practitioner see his residents. The DON confirmed the last completed note from the Physician was from EX. Order 26.(4) B1. The DON stated that the Physician was recently at the facility and could not speak to why the resident was not seen. On 2/1/23 at 1:13 PM, the surveyor interviewed the Medical Director who stated one of his job roles included coordinating with other physicians at the facility for patient care. The Medical Director stated that a resident should be seen by their physician at least monthly. On 2/2/23 at 9:27 AM, the surveyor interviewed the resident who stated it had been a long time since he/she saw the Physician. The resident stated he/she had seen the Physician in passing in the hallway, but it had been a while since they actually sat down with the Physician. On 2/2/23 at 9:52 AM, the surveyor attempted to interview the Physician via telephone at their office. The Receptionist who answered the phone stated the Physician would not be in the	F 712	ensure a progress note is being written after a face-to-face visit from the resident's Primary Care Physician, monthly for 3 months, followed by quarterly thereafter. ¿ The nursing managers/designee were in-serviced on alerting the Director of Nursing and Administration of primary care physicians who have not conducted a face-to-face visit in 30 days. ¿ Doctor will be notified if a visit has not been conducted per the guidelines ¿ Medical Director will be notified of all primary care physicians that are not compliant with timely visits and documentation, to reinforce. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The nursing managers/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 712	Continued From page 41	F 712		

office, and the surveyor left a message to call back.

On 2/2/23 at 11:53 AM, the surveyor interviewed the Physician via telephone who stated he came to the facility two to three times a month. The Physician stated he did not document his notes from these visits on all his residents and there was probably missing notes. When asked how often he saw his residents, the Physician stated he was very aware of the regulations. When asked to clarify, the Physician stated he was aware long term care residents needed to be seen once a month and that he did not have a nurse practitioner who saw his residents. The Physician stated he saw his own residents and he was in the middle of a meeting so he hung-up the phone.

On 2/3/23 at 9:03 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, Infection Preventionist/Licensed Practical Nurse (IP/LPN), and survey team acknowledged the Physician was not seeing his residents on a monthly basis.

2. On 1/27/23 at 10:52 AM, the surveyor observed Resident #55 sitting in a wheelchair in their room. The surveyor attempted to interview the resident who appeared to have some EX. Order 26.(4) B1 with their responses.

The surveyor reviewed the medical record for Resident #55.

A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 712	Continued From page 42	F 712		

included EX. Order 26.(4) B1 [redacted]

A review of the most recent annual MDS dated EX. Order 26.(4) [redacted], reflected a BIMS score of EX. Order 26.(4) B [redacted], which indicated a EX. Order 26.(4) B1 [redacted].

A review of the resident's physician visits from the past six months revealed that the resident was last seen by the Physician was EX. Order 26.(4) B1 [redacted].

On 2/1/23 at 1:13 PM, the surveyor interviewed the Medical Director who stated one of his job roles included coordinating with other physicians at the facility for patient care. The Medical Director stated that a resident should be seen by their physician at least monthly.

On 2/2/23 at 9:52 AM, the surveyor attempted to interview the Physician via telephone at their office. The Receptionist who answered the phone stated the Physician would not be in the office, and the surveyor left a message to call back.

On 2/2/23 at 11:53 AM, the surveyor interviewed the Physician via telephone who stated he came to the facility two to three times a month. The Physician stated he did not document his notes from these visits on all his residents and there was probably missing notes. When asked how often he saw his residents, the Physician stated he was very aware of the regulations. When asked to clarify, the Physician stated he was aware long term care residents needed to be seen once a month and that he did not have a nurse practitioner who saw his residents. The Physician stated he saw his own residents and he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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 712	Continued From page 43	F 712		

was in the middle of a meeting so he hung-up the phone.

On 2/2/23 at 3:16 PM, the surveyor informed the LNHA and DON that Resident #55 was last seen by their Physician on EXEX. Order 26.(4) B1

On 2/3/23 at 9:03 AM, the LNHA in the presence of the DON, IP/LPN, and survey team acknowledged the Physician was not seeing his residents on a monthly basis.

3. On 1/27/23 at 10:19 AM, the surveyor observed Resident #3 in bed with bed in the lowest position and padding on the bed side-rails. The resident responded to surveyor greetings, but then closed his/her eyes and did not further respond.

The surveyor reviewed the medical record for Resident #3.

A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses including EX. Order 26.(4) B1 , and EX. Order 26.(4) B1

A review of the most recent quarterly MDS dated EX. Order 26.(4) B1 , reflected the resident had a BIMS score of a EX. Order 26.(4) B1 , which indicated EX. Order 26.(4) B1 EX. Order 26.(4) B1

A review of the resident's physician visits from the past six months revealed that the resident was last seen by the Physician on EX. Order 26.(4) B1 . There

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 712	Continued From page 44	F 712		

was no further documentation that the resident was seen by his/her primary care Physician since then.

On 2/1/23 at 1:13 PM, the surveyor interviewed the Medical Director who stated one of his job roles included coordinating with other physicians at the facility for patient care. The Medical Director stated that a resident should be seen by their physician at least monthly.

On 2/2/23 at 9:52 AM, the surveyor attempted to interview the Physician via telephone at their office. The Receptionist who answered the phone stated the Physician would not be in the office, and the surveyor left a message to call back.

On 2/2/23 at 11:53 AM, the surveyor interviewed the Physician via telephone who stated he came to the facility two to three times a month. The Physician stated he did not document his notes from these visits on all his residents and there was probably missing notes. When asked how often he saw his residents, the Physician stated he was very aware of the regulations. When asked to clarify, the Physician stated he was aware long term care residents needed to be seen once a month and that he did not have a nurse practitioner who saw his residents. The Physician stated he saw his own residents and he was in the middle of a meeting so he hung-up the phone.

On 2/2/23 at 3:16 PM, the surveyor informed the LNHA and DON that Resident #3 was last seen by their Physician on [redacted].

On 2/3/23 at 9:03 AM, the LNHA in the presence

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 712	Continued From page 45	F 712		

of the DON, IP/LPN, and survey team acknowledged the Physician was not seeing his residents on a monthly basis.

4. On 1/27/23 at 12:05 PM, the surveyor observed the resident in bed, dressed and well groomed, wearing glasses, with blankets to his/her chest. The resident stated he/she had a EX. Order 26.(4) B1 that is EX. Order 26.(4) B1 and is attached to a EX. Order 26.(4) B1. The surveyor observed the EX. Order 26.(4) B1 hanging below the EX. Order 26.(4) in a EX. Order 26.(4) B1, fluid was EX. Order 26.(4) B1.

The surveyor reviewed the medical record for Resident #29

A review of the Admission Record face sheet reflected the resident was originally admitted to the facility in EX. Order 26.(4) B1 with diagnoses including EX. Order 26.(4) B1 y (a condition where EX. Order 2 does not EX. Order 26.(4) B1 from the EX. Order 26.(4) B1 der), EX. Order 26.(4) B1 of the EX. Order 26.(4) B1

A review of the most recent significant change MDS dated EX. Order 26.(4) B1, reflected that the resident had a BIMS score of EX. Order 26.(4) B1, which indicated a EX. Order 26.(4) B1.

A review of the resident's physician visits from the past six months revealed that the resident was last seen by the Physician was EX. Order 26.(4) B1.

On 2/1/23 at 1:13 PM, the surveyor interviewed the Medical Director who stated one of his job roles included coordinating with other physicians

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 712	Continued From page 46	F 712		

at the facility for patient care. The Medical Director stated that a resident should be seen by their physician at least monthly.

On 2/2/23 at 9:52 AM, the surveyor attempted to interview the Physician via telephone at their office. The Receptionist who answered the phone stated the Physician would not be in the office, and the surveyor left a message to call back.

On 2/2/23 at 11:53 AM, the surveyor interviewed the Physician via telephone who stated he came to the facility two to three times a month. The Physician stated he did not document his notes from these visits on all his residents and there was probably missing notes. When asked how often he saw his residents, the Physician stated he was very aware of the regulations. When asked to clarify, the Physician stated he was aware long term care residents needed to be seen once a month and that he did not have a nurse practitioner who saw his residents. The Physician stated he saw his own residents and he was in the middle of a meeting so he hung-up the phone.

On 2/2/23 at 2:28 PM, the surveyor interviewed Resident #29 who stated his/her primary care Physician did not come to see him/her very often, he was busy all the time.

On 2/2/23 at 3:16 PM, the surveyor informed the LNHA and DON that Resident #29 was last seen by their Physician on [redacted].

On 2/3/23 at 9:03 AM, the LNHA in the presence of the DON, IP/LPN, and survey team acknowledged the Physician was not seeing his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

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F 712	Continued From page 47 residents on a monthly basis. A review of the facility's "Physician Visits" policy dated reviewed 10/2022, included...after the first ninety days, if the Attending Physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits may be established, but not to exceed every sixty (60) days. A physician assistant or nurse practitioner may make alternate visits after the initial ninety (90) days following admissions, unless restricted by law or regulation... NJAC 8:39-23.2(d)	F 712		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation performed on 1/30/23, the surveyors observed two nurses administer medication to five (5) residents. There were 28 opportunities, and two (2) errors were observed, which calculated to a medication administration error rate of 7.14%. This deficient practice was identified for 1 of 5 residents (Resident # 36) that were administered medications by 1 of 2 nurses.	F 759	Jersey Shore Post Acute PLAN OF CORRECTION (POC) F759 Annual Survey 2023 Compliance Date: 3/10/2023 How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #36. ¿ Doctor was notified ¿ Medication Error form was filled out for Resident #36 ¿ LPN #1 was counseled on proper medication administration and to	3/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

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F 759	Continued From page 48 The deficient practice was evidenced by the following: On 1/30/23 at 9:15 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN) obtain a EX. Order 26.(4) B1) result of EX. Order and stated Resident #36 had a physician's order (PO) for a EX. Order 26.(4) B1 EX. Order 26.(4) B1 of EX. Order 26.; meaning that certain EX. Or results corresponded to the amount of EX. Order 26.(to be administered. There was no observed breakfast tray in the resident's room. Upon returning to the medication cart, the surveyor with the LPN reviewed the Medication Administration Record (MAR). The LPN stated that according to the PO on the MAR, the resident was to receive EX. Order 26.(4) B1 for the EX. Order 26.(4) B1 and EX. Order 26.(4) B1 of the EX. Order 26.(4) B1) insulin to total EX. Order 26.(4) B1 . EX. Order 26.(4) B1 was fast acting EX. Order 26.(that was used to control EX. Order 26.(4) B1 . The surveyor observed the LPN prepare six medications for Resident #36; which included the EX. Order 26.(4) B1). The surveyor observed the LPN administer the EX. Order 26.(EX. Order 26.(4) B1 to the resident's EX. Order 26.(4) B1 EX. Order 26.(4) B1 using an EX. Order 26.(4) B1 . (Error #1) At that time, the LPN stated the resident had breakfast and the resident confirmed that they ate their breakfast. The LPN then reviewed the MAR and stated the resident had an order for EX. Order 26.(4) B1) EX. Order 26.(4) B1 was a EX. Order 26.(4) B1 that helped control EX. Order 26.(4) B1 . The surveyor then observed the LPN prepare, then administered the EX. Order 26.(4) B1 to the resident's EX. Order 26.(4) B1 using an EX. Order 26.(	F 759	administer insulin on time to ensure all medications are administered without error. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents on insulin have the ability to be affected by not receiving their EX. Order 26.(on time. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The Unit Managers, and nurses were in-serviced on the importance of administering EX. Order 26.(on time. ¿ The DON/designee will audit 1 nurse during medication administration, to ensure that all EX. Order 26.(will be administered without error, weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The DON/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits	

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	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 759	Continued From page 49 syringe. (Error #2) On 1/30/23 at 9:45 AM, at the medication cart, the surveyor interviewed the LPN who stated that the usual insulin technique was to administer EX. Order 26.(before the resident ate breakfast. The surveyor with the LPN reviewed the MAR for Resident # 36 which revealed the EX. Order 26.(4 ordered was displaying pink. The LPN stated that when medication orders displayed pink, it was a computer alert that indicated that the medication was late to be administered. Further review indicated the EX. Order 26.(4) B1 was plotted to be administered for 7:30 AM and the EX. Order 26.(4) B1 was plotted to be administered for 8:00 AM. The LPN stated that the EX. Order 26.(4 administration for both the EX. Order 26.(4) B were late and should have been administered on time and before the resident had eaten breakfast. The surveyor reviewed the medical record for Resident #36. A review of the Admission Record face sheet reflected the resident had a diagnosis of EX. Order 26.(4) B1 EX. Order 26.(4) B1. A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4 , reflected the resident had a brief interview for mental status (BIMS) score of EX. Order 26.(EX. Order 26 which indicated a EX. Order 26.(4) B1. A review of the EX. Order 26.(4) B1 MAR included a PO dated EX. Order 26.(4) B1 solution EX. Orde ; EX. Order 26.(4) B1 EX. O :X. Order 26.(4) B1 a day every EX. Order 26.(4) B , EX. Order 26.(4) E EX. Order 26.(4 for EX. Order 26.(4) B1 lysis days; plotted to be administered at 7:30 AM.	F 759		

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	315056	A. BUILDING _____ B. WING _____	02/07/2023

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F 759	Continued From page 50 Further review of the EX. Order 26.(4) B1 3 MAR included a PO dated EX. Order 26.(4), for EX. Order 26.(4) B1 [redacted] nd call the physician. Administer EX. Order 26.(4) B1 a day every EX. Order 26.(4) B1 EX. Order 26.(4) B1, and EX. Order 26.(4) B1 on EX. Order 26.(4) B1 s days; plotted to be administered at 7:30 AM. Further review of the EX. Order 26.(4) B1 023 MAR reflected a PO dated 10/25/21, for EX. Order 26.(4) B1 EX. Order 26.(4) B1 [redacted] two times a day for EX. Order [redacted] plotted to be administered at 8:00 AM. On 1/30/23 at 9:50 AM, the surveyor interviewed the Infection Preventionist/LPN (IP/LPN) who stated it was important to administer EX. Order 26 on time because of the peak time of the medication and because of the EX. Order 26.(4) B1 in the body. On 1/30/23 at 1:50 PM, the surveyor interviewed the Director of Nursing (DON) who stated the EX. Order 26 orders should have been administered at the times ordered by the physician. The DON stated she did not know why the nurse was late with the EX. Order 26.(4 administrations. On 2/3/23 at 9:03 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and IP/LPN. The DON acknowledged that medications should be administered on time. A review of the facility's "Medication Administration" policy dated reviewed 6/2022,	F 759		

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	315056	A. BUILDING _____ B. WING _____	02/07/2023

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F 759	Continued From page 51 included...medications to be administered at the right time because medications are scheduled to avoid drug/food interactions and per manufacturer recommendations... According to information from the EX. Order 26.(4) B1 EX. Order 26.(4) B1 on EX. Order 26.(4) B1 Basics" included EX. Order 26.(4) B1 begins to work about EX. Order 26.(4) B1. In addition, information on EX. Order 26.(4) B1 Routines" reflected that "EX. Order 26.(4) B1 shots are most effective when you take them so that EX. Order 26.(4) B1 goes to work when EX. Order 26.(4) B1 from your food starts to enter your blood. For example, EX. Order 26.(4) B1 works best if you take it EX. Order 26.(4) B1 before you eat." According to the EX. Order 26.(4) B1 prescribing information included under indications and usage EX. Order 26.(4) B1 indicated to improve EX. Order 26.(4) B1 in adults and pediatric patients with EX. Order 26.(4) B1 and in adults with EX. Order 26.(4) B1 litus"...Dosage and Administration...the insulin to be administered EX. Order 26.(4) B1 at the same time every day...	F 759		
F 880 SS=D	NJAC 8:39-11.2(b) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		3/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 880	Continued From page 52	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 880	Continued From page 53 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) maintain proper infection control practices identified for 1 of 2 nurses observed during medication administration and for 1 of 4 nurses interviewed during medication storage and b.) perform hand hygiene after 1 of 6 observed kitchen staff pull their surgical mask down and then back up. This deficient practice was evidenced by the following: 1. On 1/30/23 at 9:05 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) prepare to administer medication to Resident #59. LPN #1 entered the resident's room with an infra-red thermometer scan and obtained a temperature of [redacted] degrees Fahrenheit (F). LPN #1 went to the medication cart and placed the thermometer on top of the cart without disinfecting the thermometer. The surveyor observed LPN #1 prepare and administer Resident #59	F 880	Jersey Shore Post Acute PLAN OF CORRECTION (POC) F880 Annual Survey 2023 Compliance Date: 3/10/2023 How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #59. LPN #1 involved was counseled regarding proper sanitation of infra-red thermometer and [redacted] meter after each usage of equipment. ¿ LPN #2 was counseled on the proper disinfecting wipe and wait time for disinfection when using disinfectant wipes for disinfecting [redacted] monitors. ¿ Ensured that each medication cart has 2 [redacted] monitors to allow for proper	

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	315056	A. BUILDING _____ B. WING _____	02/07/2023

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F 880	Continued From page 54 medications. On 1/30/23 at 9:15 AM the surveyor observed LPN #1 obtain a EX. Order 26.(4) B1 using a EX. Order 26.(4) B1 for Resident #36. The EX. Order 26.(4) B1 was EX. Order 26.(4) B1 LPN #1 returned to the medication cart and placed the EX. Order 26.(4) B1 on top of the medication cart. LPN #1 then placed the EX. Order 26.(4) B1 into the top drawer of the medication cart. On 1/30/23 at 9:45 AM, the surveyor interviewed LPN #1 who stated that she was not aware that she did not disinfect the thermometer and thought she did. LPN #1 acknowledged the EX. Order 26.(4) B1 was not disinfected, and that the thermometer and the EX. Order 26.(4) B1 should have been cleaned with the disinfectant wipes after each use. On 2/1/23 at 10:43 AM, the surveyor inspected the EX. Order 26.(4) B1 Wing medication cart in the presence of LPN #2. The surveyor observed an EX. Order 26.(4) B1 inside the medication cart and interviewed LPN #2 at this time. LPN #2 stated that she used the EX. Order 26.(4) B1 during her shift to check the EX. Order 26.(4) B1 of several residents before breakfast and lunch. The surveyor asked LPN #2 about the way that she cleaned and disinfected the EX. Order 26.(4) B1 between residents. LPN #2 stated that she used EX. Order 26.(4) B1 pads. The surveyor asked if LPN #2 waited a set amount of time after using the EX. Order 26.(4) B1 ep pads. LPN #2 stated, "I never really counted" but that by the time she walked to the next room that the EX. Order 26.(4) B1 was ready. LPN #2 stated that the container of disinfectant wipes was too large to bring into resident rooms and that was why she used EX. Order 26.(4) B1 EX. O pads. The surveyor	F 880	contact time after sanitizing. ¿ Food Service Director and all staff (dietary, housekeeping, recreation, therapy, nursing and administration) were in-serviced on proper hand hygiene after touching surgical mask. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All residents have the ability to be affected by not meeting the requirements of people maintaining infection control practices during medication administration and medication storage, performing hand hygiene after touching soiled surgical mask. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The facility will inservice all nurses on proper sanitization of infra-red thermometer after each usage. ¿ The facility will inservice all nurses on proper sanitization of EX. Order 26.(4) B1 se monitors and contact time after sanitizing. ¿ The facility will inservice all staff (Dietary, Housekeeping, Recreation, Therapy, Nursing and Administration) on proper hand hygiene after touching surgical masks. ¿ Infection Control Preventionist/designee will audit nurses on cleaning and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 55 asked how many EX. Order 26.(4) B1 were in the medication cart? LPN #2 responded that there should be EX. Order 26.(4) B1 in the medication cart, but that there was only one. On 2/1/23 at 11:33 AM, the surveyor interviewed the Infection Preventionist/LPN (IP/LPN). The IP/LPN stated that staff were expected to disinfect the EX. Order 26.(4) B1 between residents using disinfectant wipes and to wait two minutes before using the EX. Order 26.(4) B1 to test the EX. Order 26.(4) B1 on the next resident. The IP/LPN stated that EX. Order 26.(4) B1 pads were not an acceptable disinfectant to use on a EX. Order 26.(4) B1 . The surveyor reviewed the list of residents on the EX. Order 2 Wing who received regular EX. Order 26.(4) B1 monitoring. The list of residents included Residents #1, #19, #36, #59, #60, #62, #65. The surveyor reviewed the medical record for Resident #1: A review of the Admission Record face sheet reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses that included EX. Order 26.(4) B1) EX. Order 26.(4) B1 . On 2/1/23 at 1:07 PM, the surveyor conducted a follow-up interview with LPN #2. LPN #2 stated that Resident #1 had EX. Ord and that their EX. OrEX. O EX. Order 26 was monitored with the same EX. Order 26 EX. Order 26.(4) B1 as the other EX. Order 2 Wing residents. The surveyor asked if there was a reason why a resident with EX. Orde did not have a dedicated EX. Order 26	F 880	disinfecting infre-red thermometers, weekly for a month then monthly for 3 months then quarterly thereafter. ¿ Infection Control Preventionist/designee will audit nurses on cleaning and disinfecting EX. Order 26.(4) B1 monitors, weekly for a month then monthly for 3 months then quarterly thereafter. ¿ Increase signage throughout the facility to remind staff of proper hand hygiene practice. ¿ Topline Staff/ Infection Preventionist will be trained in Infection Preventionist Training Course: Training Program Module 1-Infection Prevention & Control Program; Module 5 Outbreaks; Module 11A- Reprocessing Reusable Resident Care Equipment. ¿ All staff(Dietary, Housekeeping, Recreation, Therapy, Nursing, and administration) will be trained on the following topics: Keep Covid 19 Out!; Sparkling Surfaces; Clean Hands; Use PPE Correctly for Covid-19; Module 11B- Environmental Cleaning and disinfection; Module 7-Hand Hygiene; Module 6A- Principles of Standard Precautions; Module 6B-Principles Of Transmission Based Precautions How the Facility will monitor its corrective actions to ensure that the deficient practice will	

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	315056	A. BUILDING _____ B. WING _____	02/07/2023

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F 880	Continued From page 56 EX. Order 26.(4) B1 that only they used. LPN #2 stated that she started at the facility EX. Order 26 months ago and that, "this is how it's been". On 2/1/23 at 1:11 PM, the surveyor conducted a follow-up interview with the IP/LPN. The IP/LPN stated that it was not discussed with her when Resident #1 was admitted whether the resident should have a dedicated EX. Order 26.(4) B1 On 2/2/23 at 11:52 AM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) of the above concerns with the EX. Order 26.(4) B1. The surveyor asked if this was how they would expect a nurse to disinfect a shared EX. Order 26.(4) B1 EX. Order 26.(4 The DON responded, "no". On 2/2/23 at 3:15 PM, the surveyor informed the LNHA and DON that LPN #1 did not sanitize the EX. Order 26.(4) B1 and EX. Order 26.(4) B1 after each use. On 2/3/22 at 9:03 AM, the DON in the presence of the LNHA, IP/LPN, Regional Infection Preventionist, Director of Clinical Services, and the survey team confirmed that the nurses should disinfect the thermometer and EX. Order 26.(4) B1 monitors after each use with disinfectant wipes. On 2/6/23 at 3:04 PM, the surveyor interviewed the IP/LPN who stated that the importance of disinfecting reusable equipment would be because they do not want to transfer organisms between residents, and she also stated that disinfectant wipes should have been used after use for both the EX. Order 26.(4) B1 and thermometer. A review of the facility's "Cleaning and	F 880	not recur, (e.g., what quality assurance program will be put into place? ¿ The Infection Control Preventionist/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine frequency of future audits	

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F 880	Continued From page 57 Disinfection of Resident-Care Items and Equipment" policy dated reviewed 12/2022, included...reusable items are to be cleaned/disinfected between before reuse by another resident... A review of the facility's "EX. Order 26.(4) B1 Meter Cleansing and Disinfecting" policy dated reviewed 9/2022, included...the glucose meter should be cleansed between each resident's use. The meter needs to be disinfected with a germicidal wipe allow to air dry... A review of the manufacturer's instructions, "EX. Order 26.(4) B1 Sample Policy and Procedures" dated 5/11, included the EX. Order 26 EX. Order 26.(4) B1 should be cleaned and disinfected between each patient test... to disinfect the meter a pre-moistened disinfecting wipe needed to be used... 2. On 1/27/23 at 10:13 AM, the surveyor accompanied by the Food Service Director (FSD) conducted a tour of the kitchen. During the tour, the surveyor observed the FSD pull down her surgical mask and continued to talk to the surveyor. When asked if the FSD should be wearing her mask to cover her mouth and nose, the FSD confirmed yes and proceeded to cover	F 880		

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F 880	Continued From page 58	F 880		

her mouth and nose with her mask. The FSD then proceeded to open the reach-in refrigerator and reached her hand into the refrigerator. At this time, the surveyor asked if there was anything she should have done after touching her mask? The FSD acknowledged she should have washed her hands and proceeded to the sink to perform hand hygiene appropriately using soap and water.

On 2/3/23 at 9:03 AM, the DON in the presence of the LNHA, IP/LPN, Regional Infection Preventionist, Director of Clinical Services, and the survey team confirmed the FSD should have washed her hands after touching her surgical mask.

A review of the facility's undated "Handwashing/Hand Hygiene" policy included...in most situations, the preferred method is washing hands with soap and water. If hands are not visibly soiled, the use of an alcohol-based hand rub may be used for the following situations:...after contact with inanimate objects...

NJAC 8:39-19.4; 27.1(a)

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	061304	A. BUILDING: _____ B. WING _____	02/07/2023

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Part A 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 as mandated by the State of New Jersey. This was evident for 6 out of 42 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	S 560	Jersey Shore Post Acute PLAN OF CORRECTION (POC) S560 Annual Survey 2023 Compliance Date: 3/10/2023 How the corrective action will be accomplished for those residents found to be affected by this practice? Part A: ¿ Affecting all residents. Email was sent out to corporate recruiter to ensure the facilities ad for new Certified Nursing Assistant was still active. Part B: ¿ Affecting Resident #82. The Administrator and Director of Nursing	3/10/23

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

Electronically Signed | 02/24/23

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One 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. During entrance conference on 1/27/23 at 9:38 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA), informed the surveyor that the facility staffing was good and the facility utilized Agency staff to cover shifts. As per the "Nurse Staffing Report" completed by the facility for the weeks of 1/8/23 to 1/14/23 and 1/15/23 to 1/21/23, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 1/8/23 had 8 CNAs for 79 residents on the day shift, required 10 CNAs. 1/9/23 had 8 CNAs for 79 residents on the day shift, required 10 CNAs.	S 560	were in-serviced on the process of notifying the Clearing House Coordinator of Nursing staff that are terminated due to incompetence, resulting in significant negative outcomes. ¿ The LPN was reported to the Clearing House Coordinator. How the Facility will identify other residents having the potential to be affected by the same deficient practice? Part A: ¿ All Residents have the ability to be affected by the facility not meeting the requirements to maintain the required minimum direct care staff to resident ratios, as mandated by the State of New Jersey. Part B: ¿ All Residents who have a significant negative outcome due to a nurse's incompetence and was terminated, have the ability to be affected by this deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? Part A: ¿ Staffing coordinator was in-serviced on the direct care staff to resident ratios. ¿ Agency contracts were reviewed to ensure the facility had outside resources in times of staffing shortages. ¿ The staffing coordinator/designee will audit direct care staffing ratios to ensure it is within the requirements as mandated by	

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S 560	Continued From page 2 1/10/23 had 9 CNAs for 79 residents on the day shift, required 10 CNAs. 1/12/23 had 9 CNAs for 77 residents on the day shift, required 10 CNAs. 1/19/23 had 8 CNAs for 72 residents on the day shift, required 9 CNAs. 1/21/23 had 8 CNAs for 72 residents on the day shift, required 9 CNAs. NJAC 8:39-5.1(a) Part B Based on interview and review of pertinent facility documents, it was determined that the facility failed to notify the Clearing House Coordinator of a Licensed Practical Nurse (LPN) who was terminated of their services after the nurse's incompetence to initiate full code emergency medical response which resulted in an unexpected death of a resident (Resident #82) as mandated by the State of New Jersey. This deficient practice was identified for 1 of 2 investigations reviewed and the findings were as followed: Reference: New Jersey Administrative Code Title 13 Law and Public Safety Chapter 45E Health Care Professional Reporting Responsibility. Subchapter 3: 13:45E-3.1 Notification to the Clearing House Coordinator by a Health Care Entity a) Except as provided in (c) below, a health care entity shall file a report with the Clearing House	S 560	the State of New Jersey, weekly for 1 month, monthly for 3 months, followed by quarterly thereafter. Part B: ¿ The Administrator & Director of Nursing were in-serviced on the process of notifying the Clearing House Coordinator Incident/Accident investigating and reporting policy which include reporting of alleged violations to the New Jersey Department of Health. ¿ The Director of Nursing /designee will audit all incidents that involve termination of any nursing staff for incompetence related to failure to initiate a full code which results in an unexpected death of a resident weekly for 1 month, monthly for 3 months and quarterly thereafter and ensure that the Clearing House Coordinator is notified. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) Part A: ¿ The Staffing coordinator/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits. Part B: ¿ The Director of Nursing/designee or Administrator will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits	

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S 560	Continued From page 3 Coordinator concerning a health care professional who is employed by, under contract to render professional services to, has clinical privileges granted by that health care entity, or who provides such services pursuant to an agreement with a health care services firm or staffing registry if: 1) For reasons relating to health care professional's impairment, incompetency or professional misconduct, which incompetency or professional misconduct relates adversely to patient care or safety, the health care entity: i) Summarily or temporarily revokes or suspends or permanently reduces, suspends or revokes the health care professional's full or partial clinical privileges or practice; ii) Removes the health care professional from the list of eligible employees of health services firm or staffing registry; iii) Discharges the health care professional from the staff of the health care entity; or iv) Terminates or rescinds a contract with the health care professional to render professional services: On 2/1/23 at 9:17 AM, the surveyor reviewed the closed medical record for Resident #82 who had expired in the facility. The surveyor reviewed the medical record for Resident #82. A review of the Admission Record face sheet	S 560		

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S 560	Continued From page 4	S 560		

reflected the resident was admitted to the facility in December of 2022 with diagnoses which included malignant neoplasm of hypopharynx and retromolar area (cancer of the throat and oral cavity), diabetes, pancytopenia (a reduction in all three major cellular elements of blood), essential (primary) hypertension (high blood pressure).

A review of the Admission/Readmission Evaluation dated 12/17/22 at 12:45 PM, reflected the resident was alert and oriented to person, place, and time with clear speech.

A review of the Order Summary Report (OSR) included a physician's order (PO) dated 12/17/22, for full code status??

A review of the Progress Notes reflected a Nursing Note (NN) dated 12/26/22 at 9:08 AM, written by the LPN who indicated the resident expired around 8:45 AM; feeding tube (a tube inserted through the wall of the abdomen into the stomach which can be used to give medications or liquids) disconnected, bathed, and groomed by Nurse and Certified Nursing Aide (CNA). Family member called and explained the situation; Physician called.

An additional NN dated 12/26/22 at 9:10 AM, written by the Infection Preventionist/LPN (IP/LPN) indicated upon entering the building this nurse was called to resident's room; resident was noted with no blood pressure, no pulse, 911 was immediately called since resident was a full code.

A NN dated 12/26/22 at 10:10 AM, written by the IP/LPN indicated paramedics on scene, no blood pressure or heart rate maintained. Resident was pronounced dead by physician [name redacted] at 10:04 AM with family at bedside.

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S 560	Continued From page 5 On 2/1/23 at 9:33 AM, the surveyor attempted a phone interview with the LPN who did not answer. The surveyor left a message to call back. On 2/1/23 at 9:40 AM, the surveyor interviewed the IP/LPN who stated Resident #82 expired at the facility. The IP/LPN stated she was not in the building when the situation occurred, she walked into the building with paramedics arriving right after. The IP/LPN continued a family member was in with the resident, so she offered emotional support. The LPN, who was an Agency Nurse, was the nurse at the time of the death. On 2/1/23 at 10:19 AM, the surveyor interviewed the Director of Nursing (DON) who stated Resident #82 was a short-term resident at the facility and was very sick with cancer. The day the resident expired, there was an Agency Nurse (LPN) who was flustered when she went into the resident's room; she tried to get the code status; called the Physician and family member; called 911, but she did not initiate CPR. The DON stated she obtained a statement from the LPN and conducted an investigation. On 2/1/23 at 10:35 AM, the DON provided the surveyor with the LPN's statement dated 12/26/22, which indicated the nurse was assigned to the resident that morning. The resident was seen during rounds with their feeding tube running; they took vital signs; preformed mouth care; and administered medication for their blood pressure of 150/99. The resident was alert and did not verbalize any discomfort, no facial grimacing, and breathing unlabored. Around 8:40 AM, the Registered Dietitian (RD) informed her the resident was slumped over leaning in their bed. The LPN stated she rushed to the resident's	S 560		

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S 560	Continued From page 6	S 560		

room with the CNA and noted the resident was slumped over an non-responsive. The LPN began to "panic" and she shook the resident and took vital signs, but there was no pulse. The LPN asked the CNA to get to the DON, and the CNA informed them they were coming. The LPN reported being "so flustered trying to think what to do". The LPN called the Physician and then called the resident's family member. When on the computer, the LPN noticed the resident was a full-code and went into "full blown panic mode", and she went back into the room to start CPR. The family member was in the room at this time and did not want me to start CPR. The LPN left the room to give them privacy and saw the Licensed Nursing Home Administrator (LNHA) who asked if 911 was called. The LPN stated "no" and proceeded to call 911.

On 2/1/23 at 1:13 PM, the surveyor interviewed the Medical Director (MD) via telephone who stated a full-code status meant the resident wanted everything done; which included calling 911, initiating basic CPR or advanced CPR with an automated external defibrillator (AED; a device used to deliver an electric shock to the heart to restore heart rhythm). The MD stated if the resident was a full-code and non-responsive, the nurse would immediately call a code and all staff would be helping assist. One staff member would immediately call 911, while another staff would start CPR until paramedics arrived who would then take over. The MD stated that unless the family member was the medical Power of Attorney (POA), they could not authorize staff to stop CPR.

At this time, the surveyor reviewed the LPN's statement with the MD. The surveyor asked if the LPN should have called the Physician first and

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S 560	Continued From page 7	S 560		

then the family member when the resident was non-responsive, the MD replied no, you would call EMS first and initiate CPR which were the important part of the code. The MD stated the patient was always first, not notifying the Physician or family, and the nurse should never leave the resident during a code.

On 2/1/23 at 1:58 PM, the surveyor interviewed the DON who confirmed the resident was a full-code status which meant the resident wanted all treatments to revive them including being sent to the hospital and CPR. If the resident was a full-code and non-responsive, the first thing the nurse would do was call the code and other staff would come. The LPN should never leave the resident, other staff would be delegated to check the code status, call EMS, start CPR, grab the crash cart which contained the AED and oxygen. The LPN who was CPR certified would have continued to perform CPR until EMS arrived and took over. The DON confirmed the LPN did not call the code, and 911 was not notified immediately, and CPR was not initiated immediately. The DON also confirmed the family member was not the POA, so the nurse should have initiated CPR despite the family's request not to. The DON stated the facility conducted an investigation to determine why the LPN who was an Agency Nurse did not call the code. The DON stated she informed the LPN's Agency that the facility did not want her back because of her incompetency, but acknowledged she did not notify the Clearing House.

On 2/2/23 at 10:21 AM, the surveyor re-interviewed the DON who stated she choose to investigate this incident to determine where the system breakdown was because this was basic nursing. The DON stated she did report the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061304	A. BUILDING: _____ B. WING _____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND	101 WALNUT STREET NEPTUNE, NJ 07753

(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 8 incident to the Agency, she thought the Agency would report the nurse. NJAC 8:39-5.1(a)	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061304 Y1	A. Building B. Wing Y2	3/20/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/10/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/7/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO