| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315218 | A. BUILDING _____ B. WING _____ | C 07/08/2022 |

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| **SEACREST REHABILITATION AND HEALTHCARE CENTER** | **1001 CENTER ST LITTLE EGG HARBOR TW, NJ 08087** |

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| F 000 | INITIAL COMMENTS<br><br>Complaint #: NJ150911, NJ151289, and NJ151502<br>Census: 109<br>Sample Size: 10<br><br>The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.<br><br>Survey date: 07/06/2022-07/08/2022 | F 000 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR | F 656 | | 8/3/22 |

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

Electronically Signed | 08/01/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 656 | Continued From page 1<br>recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Complaint Intake NJ150911<br><br>Based on observations, interviews, and record reviews, it was determined the facility failed to implement care planned interventions related to falls for 1 (Resident #1) of 3 residents reviewed for falls.<br><br>Findings included:<br><br>1. A review of Resident #1's "Admission Record" revealed the resident had diagnoses which included a *Ex Order 26. 4B1* [redacted] | F 656 | Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth or the facts alleged, or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws that require it.<br><br>Resident # 1 NJ Exec. Order 26:4.b.1 care plan was reviewed and updated. The facility ensured that all interventions included in the plan of care were implemented immediately. Resident did not experience any negative effects.<br><br>All residents at risk for falls have the potential to be affected by this deficient practice. | |

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| F 656 | Continued From page 2<br><br>A review of Resident #1's quarterly Minimum Data Set (MDS), dated Ex Order 26. 4B1, indicated the resident had a Ex Order 26. 4B1 score of [redacted] out of 15, indicating Ex Order 26. 4B1. The resident required extensive assistance to total dependence from staff for all Ex Order 26. 4B1 except the resident was able to feed themself with set up only. The resident had had one [redacted] at the time of completing this assessment. The resident had one [redacted] at the time of this assessment.<br><br>A review of the "Care Plan Activity Report," effective Ex Order 26. 4B1, revealed the resident was at risk for [redacted] related to an Ex Order 26. 4B1 and was at risk for [redacted] related to [redacted]. An intervention included a NJ Exec. Order 26:4.b.1 and a Ex Order 26. 4B1. This intervention was effective on Ex Order 26. 4B1.<br><br>During an observation conducted with the Director of Nursing (DON) on 07/06/2022 at 10:07 AM, Resident #1 was observed sitting in a standard wheelchair in the facility's dining room on the third floor. The resident did not have their Ex Order 26. 4B1 clipped on them during this observation. The observation revealed the cord attached to the Ex Order 26. 4B1 was wound around the left push handle of the wheelchair. The DON did not correct the intervention during this observation.<br><br>During a follow-up observation on 07/06/2022 at 2:50 PM, Resident #1 sat in their standard wheelchair in the facility's dining room on the third floor. The resident did not have their Ex Order 26. 4B1 clipped on them during this observation. The observation revealed the cord attached to the | F 656 | All residents with a care plan for being at risk for falls were reviewed and evaluated to ensure care planed interventions were implemented. No other residents were affected.<br><br>Staff were educated regarding care plan updates post fall being completed by the Unit Manager/designee in timely manner as per facility policy with new interventions added to the care plan after each fall and ensuring implementation of interventions immediately.<br>Staff were also educated on ensuring existing preventative interventions listed on the care plan are in place according to the care plan.<br>Education provided to staff regarding alarm placement OOB and checking for functioning as per orders. Education provided to the staff regarding the need for the resident to utilize dropped back w/c. Education provided to the staff to remain with the resident with the distance of the arm length if the resident is seated in standard w/c due to W/c repair or cleaning.<br><br>Unit Manager/designee will perform an audit, on 5 residents, to ensure care planned fall prevention interventions, including level of supervision are implemented daily x1week then, weekly x4 weeks. Results of the audits will be reported to and reviewed by the QA committee to determine if further action or continuation of audits is required. | |

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| F 656 | Continued From page 3 | F 656 | | |

Ex Order 26. 4B1 was wound around the left push handle of the wheelchair.

On 07/06/2022 at 2:51 PM, Certified Nurse Aide (CNA) #1 verified the Ex Order 26. 4B1 was not clipped to the resident. She verified the placement of the Ex Order 26. 4B1 in relation to the wheelchair push handle as described above. CNA #1 stated the Ex Order 26. 4B1 needed to be clipped so that it alerted staff when the resident attempted to stand. She verified that the Ex Order 26. 4B1 would not perform its intended function, given it was not clipped to the resident. She stated she had not observed the resident pull on the chair alarm.

On 07/06/2022 at 2:53 PM, Unit Manager (UM) #1 on the third floor for the 7:00 AM to 3:00 PM shift verified the resident's Ex Order 26. 4B1 was not clipped on the resident. UM #1 verified the placement of the Ex Order 26. 4B1 in relation to the wheelchair push handle as described above. She stated she had not seen the resident remove the Ex Order 26. 4B1 when it was clipped on them before. She stated that failure to ensure the resident's Ex Order 26. 4B1 was clipped on the resident failed to ensure the Ex Order 26. 4B1 was able to perform its function.

On 07/07/2022 at 10:41 AM, the surveyor observed the resident's wheelchair while the resident sat in it. The observation was initially started with the surveyor and the DON present; however, the Director of Rehab (DOR) later joined in on the observation. Although the facility had the Ex Order 26. 4B1 clipped on Resident #1 during this observation, the DOR verified that Resident #1 sat on a standard wheelchair. Per the DOR, a standard wheelchair could not be Ex Order 26. 4B1. The DOR verified the seat on the wheelchair

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| F 656 | Continued From page 4 | F 656 | | |

Resident #1 sat in at the time of the observation was not [Ex Order 26. 4B1] as care planned. The DOR stated it was important to keep the resident's wheelchair [Ex Order 26. 4B1] so that it prevented the resident from sliding forward and possibly falling off the wheelchair. The DON stated she followed up on the resident after the surveyor brought the facility's attention to the observation regarding the facility's failure to ensure the facility had the [Ex Order 26. ] clipped on the resident from the day before. She stated she worked in conjunction with the DOR to ensure the facility implemented all the interventions that were care planned to address Resident #1's [NJ Exec. Order] She stated the wheelchair was part of what she addressed and did not understand why the resident sat in the improper wheelchair. The DON stepped out of the dining area and returned a few minutes later to call the surveyor's attention to the presence of a wheelchair in the hallway that was the correct specification of wheelchair that was supposed to be used for the resident. Per the DON, staff reported to her that the wheelchair ([Ex Order 26. 4B1] ) assigned to Resident #1 was taken out to be cleaned.

During an interview on 07/07/2022 at 11:19 AM, CNA #2 (the aide assigned to Resident #1 on the 7:00 AM to 3:00 PM shift) stated she was aware of the [NJ Exec. Order 26:4.b.1] in place for the resident. CNA #2 listed Resident #1's fall interventions to include, but not limited to, a [Ex Order 26. 4B1] and [Ex Order 26. 4B1]. She stated the interventions were monitored every day to make sure they were in place and worked. She verified the resident was not in a dropped wheelchair as care planned. She stated the dropped wheelchair needed to be cleaned, and the replacement wheelchair brought up for the resident's

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| F 656 | Continued From page 5<br>temporary use was not designed to have its seat [Ex Order 26. 4B1].<br><br>On 07/07/2022 at 12:01 PM, Licensed Practical Nurse (LPN) #1 stated it was important to follow through on formulated care plan interventions related to [NJ Exec. Orde] to ensure the resident did not [NJ Exec.] again.<br><br>During an interview on 07/07/2022 at 12:24 PM, Resident #1's family member stated they had had to call nursing staff's attention to the facility's failure to ensure that the [NJ Exec. Order 26:4.b.1] put in place for Resident #1 were followed. Per Resident #1's family member, they had visited the facility on several occasions and had observed the resident's [NJ Exec. Order 26:4.b.1], which recommended to have a [Ex Order 26. 4B1], was not implemented.<br><br>On 07/07/2022 at 2:33 PM, the Medical Director (MD) stated her expectation was that the facility devise new interventions to address a resident's [NJ Exec.] and for the facility to always follow their formulated interventions.<br><br>During an interview on 07/08/2022 at 1:00 PM with the DON and the Administrator, the DON acknowledged that Resident #1's [Ex Order 26. 4B1] was not in place at the time of her joint observation with the surveyor on 07/06/2022 at 10:07 AM. The Administrator stated that he expected all interventions in place to address the resident's [NJ Exec. Or] were followed. | F 656 | | |
| F 689 SS=D | New Jersey Administrative Code § 8:39-11.2(f) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) | F 689 | | 8/3/22 |

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| F 689 | Continued From page 6<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Complaint Intake NJ150911<br><br>Based on observations, interviews, record review, and review of the facility policy, it was determined the facility failed to ensure that 1 resident (Resident #1) out of 3 residents reviewed for [NJ Exec. Orde] received adequate supervision to prevent additional [NJ Exec. Orde].<br><br>Findings included:<br><br>1. A review of Resident #1's admission Minimum Data Set (MDS), dated [Ex Order 26. 4B1], the resident required supervision with walking and limited assistance with [Ex Order 26. 4B1]. The resident had a [Ex Order 26. 4B1] score of [Ex] out of 15, indicating [Ex Order 26. 4B1]. Active diagnoses included [Ex Order 26. 4B1].<br><br>The quarterly MDS, dated [Ex Order 26. 4B1], indicated the resident was [Ex Order 26. 4B1], with a [Ex Order 26. 4] score of [Ex] out of 15. The resident required [Ex Order 26. 4B1] except the resident was able to feed themself with set up only. The resident had had [NJ Exec. Order 26-4] at the time of | F 689 | Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth or the facts alleged, or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws that require it.<br><br>Resident #1 The wheelchair that was removed for cleaning while the resident remained on 1:1 supervision with staff, was returned to the resident. Resident did not experience any negative effects during that time.<br>Resident #1 [Ex Order 26. 4B1] was reapplied, remained on, and functioning properly. Resident #1 remained in an area supervised by staff while the alarm was not attached. Resident did not experience any negative effects.<br><br>All residents at risk for falls requiring supervision have the potential to be affected by this deficient practice.<br>All residents with a care plan for at risk for falls that included supervision | |

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| F 689 | Continued From page 7<br>completing this assessment. The resident had [NJ Exec. Order 26:4.b.1] at the time of this assessment. Active diagnoses included *Ex Order 26. 4B1* [redacted].<br><br>A review of the "Admission Record" revealed the facility re-admitted Resident #1 with diagnoses that included a *Ex Order 26. 4B1* [redacted].<br><br>According to Resident #1's admission [NJ Exec. Order 26:4] assessment, dated *Ex Order 26. 4B1*, the facility identified that Resident #1 was *Ex Order 26. 4B1* [redacted] and a *Ex Order 26. 4B1* as risk factors predisposing the resident to [NJ Exec. O]. The assessment revealed Resident #1 had a total score of [Ex Ord] for a [NJ Exec. Order 26:4.b.1] and recommended implementing a [NJ Exec. Order 26:4.b] plan for the resident. The assessment did not have a scale with which to compare Resident #1's score.<br><br>A review of Resident #1's "Care Plan Activity Report" revealed the facility initiated the following interventions on *Ex Order 26. 4B1*. The care plan identified Resident #1 was at [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order] related to an *Ex Order 26. 4B1*. The | F 689 | interventions were reviewed to ensure adequate supervision was in place. No other residents were affected.<br><br>Education was provided to staff regarding adequate supervision to prevent falls. The education included the different types of supervision, what is required for each type and facility policy related to supervision to prevent falls.<br>An audit was completed for all residents at risk for falls to determine if they required supervision, if so what type and the care plans/Kardex□s were updated to include specified supervision as indicated.<br>The IDT team was educated on review of new/re admissions fall risk assessments to determine level of supervision required to prevent falls, daily in morning meeting and update the care plan/Kardex to include level of supervision as applicable. This will also be reviewed by the IDT team quarterly and as needed.<br><br>Unit Manager/designee will perform an audit, on 5 residents, to ensure care planned fall prevention interventions, including level of supervision are implemented daily x1week then, weekly x4 weeks.<br>Results of the audits will be reported to and reviewed by the QA committee to determine if further action or continuation of audits is required. | |

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| F 689 | Continued From page 8<br>interventions portion included:<br>- Bed in low position.<br>- Motion sensors in the [Ex Order]' position when resident was in bed.<br>- Make sure the call bell was within easy reach and any needed objects were close at hand.<br>- Keep the resident's room well-lit and free of clutter.<br>- Provide the resident with the proper footwear for ambulation.<br>- Provide the resident with non-skid socks in bed.<br>-[Ex Order 26. 4B1] to evaluate, treat as appropriate, ordered by the physician.<br><br>A review of the rehabilitation (rehab) departments notes showed the resident received [Ex Order 26. 4B1] from [Ex Order 26. 4B1], five times a week.<br><br>The resident was residing in a [Ex Order 26. 4B1] unit due to wandering.<br><br>A review of Resident #1's medical record revealed the following falls:<br><br>a. [Ex Order 26. 4B1] at 2:45 PM: Resident #1 was walking in the dining room wearing non-skid footwear, [NJ Exec. Order 26:4.b.1]. There were [NJ Exec] There were activity aides present in the dining room at the time of [NJ Exec. Order 26:4] The interdisciplinary care team (IDC) reviewed [NJ Exec. Order 26:4] and determined the resident's plan of care had been followed and medications were not the cause of [NJ Exec. Order 26:4]. There were no additional interventions added at that time.<br><br>b. [Ex Order 26. 4B1] at 1:00 PM: Resident #1 was again walking in the dining room [NJ Exec. Order 26:4]. The resident | F 689 | | |

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received Ex Order 26. 4B1 to the top of the Ex Order 26. 4B1 , and NJ Exec. Order 26:4.b to the Ex Order 26. 4B1 of the resident's Ex Order 26. . Resident #1 complained of NJ Exec. Ord in the Ex Order 26. 4B1 . An order was received to send the resident to the Ex Order 26. 4B1 for evaluation. A review of the ER notes, dated Ex Order 26. 4B1 , revealed the final radiology report indicated Resident #1 sustained an Ex Order 26. 4B1 through the Ex Order 26. 4B1 and an Ex Order 26. 4B1 with Ex Order 26. 4B1 . Resident #1 underwent Ex Order 26. 4B1 and was Ex Order 26. 4B1 for 11 days following the NJ Exec. Ord The IDC reviewed the NJ Exec. O and determined they would revisit the plan of care when the resident returned from the Ex Order 26. 4B1 . When the resident returned from the Ex Order 26. 4B1 , the resident began receiving Ex Orde five times a week from Ex Order 26. 4B1 except when the resident was in the Ex Order 26. 4B1 from Ex Order 26. 4B1 .

c. Ex Order 26. 4B1 at 4:36 PM: The resident was found on the floor of their room. A floor mat was in place. An unidentified certified nurse aide (CNA) reported seeing the resident in bed after their session with NJ Exec. Order 26 . The resident denied NJ Exec. Ord and there were NJ Exec. Order 26:4.b.1 . The resident was wearing non-skid socks at the time. The IDC determined that the Ex Order 26. 4B1 was not in the NJ Exec. O position as was care planned. Education was provided to staff.

d. Ex Order 26. 4B1 at 5:00 PM: The resident again NJ Exec. O in the dining room. The resident was wearing sneakers and the floor was clean, dry, and free of clutter. The resident Ex Order 26. 4B1 but there was NJ Exec. Order 26:4.b.1 found during the assessment. An order was received to send the

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| SEACREST REHABILITATION AND HEALTHCARE CENTER | 1001 CENTER ST LITTLE EGG HARBOR TW, NJ 08087 |

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| F 689 | Continued From page 10<br>resident to the [redacted] for evaluation.<br><br>A review of a progress note, dated Ex Order 26. 4B1, indicated an [redacted] showed a Ex Order 26. 4B1 [redacted]. The resident underwent Ex Order 26. 4B1 [redacted]. The resident returned to the facility on Ex Order 26. 4B1.<br><br>The IDC reviewed the [redacted] and determined all plan of care and nursing instructions were being followed correctly. The IDC recommended changing the resident's seating position to the middle of the dining room where they would be more visible to staff. This intervention was not transcribed to the resident's care plan timely.<br><br>e. Ex Order 26. 4B1 at 3:30 PM: The resident was found on the floor of the resident's room kneeling in front of the wheelchair. The resident's arms were extended, holding the arms of the wheelchair. The resident was able to perform Ex Order 26. 4B1 to all extremities without NJ Exec. Order 26:4.b.1. There were no apparent [redacted] found during the assessment. The IDC recommended safety checks every shift for the resident during their review of [redacted]. The resident was wearing non-skid footwear.<br><br>f. Ex Order 26. 4B1 at 11:20 AM: The resident [redacted] in the dining room. Per the incident report, dated Ex Order 26. 4B1, the resident attempted to walk toward the windows in the dining room. The resident sustained two Ex Order 26. 4B1 to their [redacted]; Ex Order 26. 4B1 were applied and covered with a dressing. Resident #1 NJ Exec. Order 26:4.b.1 and was transferred into the wheelchair. A small, [redacted] area to the Ex Order 26. 4B1 was noted on the [redacted] assessment completed with the resident. The recommended intervention following [redacted] from | F 689 | | |

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| F 689 | Continued From page 11 | F 689 | | |

the IDC notes was to have Resident #1's wheelchair seat tilted backward, a [Ex Order 26. 4B1] to be applied, and moving the resident's position to a more visible area of the dining room.

The following observations were made during the two-day survey:
- On 07/06/2022 at 10:07 AM, with the Director of Nursing (DON), the [Ex Order 26. 4B1] was not attached to the resident but was wound around the left handle of the wheelchair. The DON did not correct the intervention during the observation. There were no staff observed within a reactionary distance from the resident.
- On 07/06/2022 at 2:50 PM the surveyor again observed the resident in the dining room with the [Ex Order 26. 4B1] not attached to the resident. It was observed to be wrapped around the handle of the wheelchair. CNA #1 verified in an interview at that time that the [Ex Order 26. 4B1] was not attached to the resident. She stated she had not observed the resident pulling on the clip alarm. During a follow up interview with CNA #1 on 07/07/2022 at 11:05 AM, she was not employed with the facility at the time Resident #1 was reported to have [NJ Exec. Order 26]. She stated she was not able to speak to the level of supervision the resident received at the time of the [NJ Exec. Ord] She clarified she knew to seat the resident in a position that aided good visibility. She stated she was not able to keep her eyes on Resident #1 all of the time as she had other residents assigned to her.
- On 07/06/2022 at 2:53 PM, with Unit Manager (UM) #1 in the dining room, verified that the [Ex Order] [redacted] was not attached to Resident #1. The [Ex Order] was wound around the handle of the wheelchair. UM #1 stated she had never seen Resident #1 remove the [Ex Order 26. 4B1]. Per UM #1, she believed Resident #1 repeatedly attempted to

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| F 689 | Continued From page 12 | F 689 | | |

walk, without the understanding they were not able to do so anymore. She stated Resident #1 stood up sometimes, but never tried taking a step. She acknowledged that the intervention to have the resident in a more visible sitting position in the dining room after the resident's [NJ Exec. O] on [Ex Order 26. 4B1] was not transcribed to the care plan. She stated the DON was responsible for updating the care plan.

- On 07/07/2022 at 10:41 AM the surveyor observed the resident's wheelchair was not tilted as per the care plan although the [Ex Order 26. 4B1] was on the resident during that observation. The observation was initially started with the surveyor and the DON present; however, the Director of Rehab (DOR) later joined in on the observation. There was no staff observed within a reactionary distance from the resident at the time of the observation. The DOR verified the seat on the wheelchair Resident #1 sat in at the time of the observation was not [Ex Order 26. 4B1] as care planned. The DON stated she followed up with the resident after the surveyor brought the facility's attention to the observation regarding the facility's failure to ensure the facility had the [Ex Order 26. 4B1] clipped on the resident from the day before. She stated she worked in conjunction with the DOR to ensure the facility implemented all the interventions that were care planned to address Resident #1's [NJ Exec. Ord] She stated the wheelchair was part of what she addressed and did not understand why the resident sat in the wrong type of wheelchair. The DON stated the resident's wheelchair had been taken out to be cleaned. The resident now had the correct type of wheelchair. This was verified by the surveyor.

During an interview on 07/07/2022 at 11:19 AM, CNA #2 (the aide assigned to Resident #1 on the

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| F 689 | Continued From page 13<br>7:00 AM to 3:00 PM shift) stated she was aware that the resident Ex Order 26. 4B1 related to NJ Exec. Orde She clarified she did not observe any of the NJ Exec. Orde Per CNA #2, she was aware of NJ Exec. Order 26.4 interventions in place for the resident. CNA #2 listed Resident #1's fall interventions to include, but not limited to, a Ex Order 26. 4B1 and Ex Order 26. . She stated the resident's wheelchair needed to be cleaned, and the replacement wheelchair brought up for the resident's temporary use was not designed to have its seat Ex Order 26. 4B1. She acknowledged there was not a wheelchair available that could have the seat tilted when Resident #1's wheelchair needed to be cleaned. Her understanding was that a staff sat with the resident to ensure the resident was safe until their original wheelchair was returned. She stated she participated in the resident's transfer from their original wheelchair to the replacement wheelchair and verified she did not sit with the resident. She stated she had asked Recreation Aide (RA) #1 to sit with the resident. She did not know why there was no one with the resident when the surveyor observed the resident.<br><br>During an interview on 07/07/2022 at 11:36 AM, RA #1 stated she was told to keep an eye on the resident. RA #1 clarified she was not told to sit with the resident. Per RA #1, she could not sit with Resident #1 because she had to help other residents. She stated the resident was weaker now than when they newly admitted and rarely attempted to stand anymore.<br><br>On 07/07/2022 at 12:01 PM, Licensed Practical Nurse (LPN) #1 stated she was primarily the full-time nurse with the resident. She stated the resident had NJ Exec. Order 26.4.b.i resulting from rolling from | F 689 | | |

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or standing in the dining room. She stated she did not witness any of the resident's [NJ Exec. Orde]. She stated she did the facility's assessment of the resident and identified the resident's [NJ Exec. O] resulted from the resident attempting to get out of their chair. She stated [NJ Exec. Order 26:4.b.1] were either safety precautions or interventions. Per LPN #1, the IDC updated the residents' care plans. LPN #1 added that it was important to follow through on formulated care plans related [NJ Exec. Order 26:4] to try to prevent any future [NJ Exec. Order]

During an interview on 07/07/2022 at 12:24 PM, Resident #1's family member stated they were unhappy about how the resident went in the facility [NJ Exec. Order 26:4.b.1] but had now declined to the point the resident could [NJ Exec. Order 26:4.b.1]. Per Resident #1's family member, they were informed of every [NJ Exec. O] the resident sustained at the facility including the ones [NJ Exec. Order 26:4.b.1]. The family member had to call nursing staff's attention to the [Ex Order 26. 4B1] not being attached to the resident. The family member stated that when they spoke with unidentified nursing staff at the facility, they were told that the resident was no longer able to ambulate so was no longer a [NJ Exec. Order 26:4.b.1]; the resident no longer needed to have the [Ex Order 26. 4B1].

During an interview on 07/07/2022 at 12:43 PM, the Director or Rehab (DOR) stated Resident #1 admitted from the community due to [NJ Exec. Order 26:4.b.1] The DOR verified he had no record to suggest his department evaluated the resident for [NJ Exec. Order 26:4] during the resident's initial admission. Per the DOR, the lack of [NJ Exec. Order 26:4.b.1] of Resident #1 was because the resident was [NJ Exec. Order 26:4.b.1] upon the resident's first admission. He stated he only conducted visual observation of the resident

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| F 689 | Continued From page 15<br>and determined the resident would not be needing an assessment. The DOR stated there was no documentation of his visual assessment of the resident. He stated there was no Ex Order 26. 4B1 made to evaluate the resident following the NJ Exec. Order 26:4.b.1. Per the DOR, the first time the rehab department evaluated Resident #1 was on Ex Order 26. 4B1 after the resident returned from the Ex Order 26. 4B1 following the fall on Ex Order 26. 4B1.<br><br>On Ex Order 26. 4B1 at 2:33 PM, the Medical Director (MD) stated she was part of the facility's IDC team and had been the MD at the facility for over ten years. The MD stated she held IDC meetings with the facility's administration monthly. Per the MD, the IDC discussed wounds, falls, weight loss, medications, hospitalization et cetera (etc.) during those meetings. The MD stated the goal of the IDC was to identify what seemed to be a trend and to address the identified trend accordingly. The MD acknowledged that Resident #1 declined in their functional abilities resulting NJ Exec. Order 26:4.b.1 .<br><br>On Ex Order 26. 4B1 at 4:59 PM, the Regional Director of Risk Management (RDRM) stated the facility's process on admission was that a fall risk assessment which placed a resident at low, moderate, or high fall risk was completed by the IDC team with all new admissions. The RDRM stated that, based on where the resident scored on that spectrum, the facility's IDC formulated appropriate fall interventions. Per the RDRM, the facility was under a different management company before it was bought by the current management company. The RDRM stated that when the new management took over the facility back in Ex Order 26. 4B1, the risk management assessment identified the facility did not make a | F 689 | | |

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| F 689 | Continued From page 16<br>root cause analysis in their fall investigations.<br><br>During an interview on 07/08/2022 at 1:00 PM with the DON and the Administrator, the DON stated she was not employed with the facility at the time pertinent to Resident #1's admission. She stated she could only speak to what the facility did since she took office in Ex Order 26. 4B1. The DON acknowledged that Resident #1's chair alarm was not in place at the time of her joint observation with the surveyor. However, she stated she believed Resident #1 was in the appropriate wheelchair (Ex Order 26. 4B1 ) during the initial observation with the surveyor on 07/06/2022 at 10:07 AM. Although the DON acknowledged that Resident #1 sat in a standard wheelchair during the subsequent observation conducted jointly with the surveyor and the DOR on 07/07/2022 at 10:41 AM, she stated Resident #1 only sat in the wheelchair temporarily while waiting on their Ex Order 26. 4B1 to be cleaned. She stated an activity staff member (RA #1) was in the dining room to monitor the resident. The DON acknowledged there were 17 other residents in the dining room in addition to Resident #1 who were being equally supervised by RA #1. The DON refuted CNA #2's assertion that staff were supposed to sit with the resident pending the return of the resident's cleaned wheelchair. To the contrary, the DON stated the facility did not do one-on-one supervision. She stated that residents only needed to be within line of sight and reactionary distance so that staff were able to respond when the resident attempted to do anything unsafe. The DON stated the change to the care plan was driven after the IDC met and discussed new approaches to a resident's care. She stated that she expected the discussion and recommendation of the IDC to be | F 689 | | |

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transcribed into the care plan. The DON verified the care plan discussed during the IDC meeting following Resident #1's fall on Ex Order 26. 4B1 was not transcribed into the care plan. The DON stated every intervention the facility did since the beginning of her employment was transcribed in the care plan. Per the DON, it was important to transcribe all recommended interventions into the care plan so that staff were able to use it to approach the care provided to the resident. The Administrator reiterated the facility switched management in Ex Order 26. 4B1. He acknowledged that the new management inherited the past and the present of the facility. He stated his expectation was that the recommendation made during the care plan committee meetings were transcribed in the care plan. He added that he expected all interventions in place to address the resident's NJ Exec. Orde were followed. The Administrator stated he was not able to speak to whether the facility's investigations into Resident #1's NJ Exec. Orde made a root cause analysis. He stated he believed the facility intervened appropriately. He stated the facility had a record of a sign-in sheet which showed the DOR participated in the facility's NJ Exec. Order 26:4 assessment conducted with Resident #1 on admission. He verified there was no documentation in Resident #1's medical record that attested to that assertion.

During an interview on 07/08/2022 at 1:13 PM, the Regional Director of Operations (RDO) reiterated that most of the NJ Exec. Orde identified in Resident #1's medical record were from the previous management. The RDO acknowledged that Resident #1 had NJ Exec. Order 26:4.b.1 under the new management on Ex Order 26. 4B1. Per the RDO, he reviewed the facility's investigation

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| F 689 | Continued From page 18<br>following Resident #1's [NJ Exec. O] on *Ex Order 26. 4B1*. He stated it did appear the investigation did not specifically make a root cause analysis, but the RDO felt that by putting an intervention in place to have the resident in near view of staff, it was safe to say that the facility felt that not having the resident within view enough allowed the resident [NJ Exec. Order].<br><br>A review of the facility's undated policy titled, "Fall Risk Assessment," revealed, "Policy Statement: The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information ...9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable."<br><br>New Jersey Administrative Code: §8:39-27.1(a) | F 689 | | |

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| S 000 | Initial Comments<br><br>Complaint #: NJ150911, NJ151289, and NJ151502<br>Census: 109<br>Sample Size: 10<br><br>TYPE OF SURVEY: Complaint Survey<br><br>The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities.<br><br>The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of 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<br><br>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint Intake NJ151289<br><br>Based on interviews, facility document review, and review of the New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met for 26 day shifts and 3 night shifts out of 90 total shifts reviewed. This deficient practice had the potential to affect all | S 560 | Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth or the facts alleged, or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws that require it. | 8/3/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/01/22

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| S 560 | Continued From page 1<br>residents.<br><br>Findings included:<br><br>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, 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:<br><br>One certified nurse aid to every eight residents for the day shift.<br><br>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 certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and<br><br>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 certified nurse aide and perform certified nurse aide duties.<br><br>1. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 01/02/2022 - 01/18/2022, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 26 of 28 day shifts and 3 of 28 night shifts as follows: | S 560 | No residents were identified<br><br>Residents of the facility have the potential to be affected<br><br>Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week.<br>The facility has developed a Culture Committee focused on recruitment. and retention of staff along with customer service and the employee experience.<br>The facility has implemented the Care Champion Program to mentor new employees which has been proven to raise retention rates.<br>The facility participates in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes.<br>Contract staff utilization is reviewed bi-weekly to identify trends and opportunities.<br>The facility has contracts in place with multiple staffing agencies as an effort to provide additional staff when needed.<br>The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, Increased utilization of PRN staff, Implementation of OnShift, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Contract staff utilization, Implementation of Temporary Nurse Aide | |

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| SEACREST REHABILITATION AND HEALTHCA | 1001 CENTER ST LITTLE EGG HARBOR TW, NJ 08087 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 560 | Continued From page 2<br>01/02/2022 had 8 CNAs for 106 residents on the day shift, required 13 CNAs.<br>01/03/2022 had 8 CNAs for 106 residents on the day shift, required 13 CNAs.<br>01/04/2022 had 8 CNAs for 106 residents on the day shift, required 13 CNAs.<br>01/05/2022 had 8 CNAs for 106 residents on the day shift, required 13 CNAs.<br>01/06/2022 had 8 CNAs for 106 residents on the day shift, required 13 CNAs.<br>01/07/2022 had 8 CNAs for 108 residents on the day shift, required 13 CNAs.<br>01/08/2022 had 10 CNAs for 110 residents on the day shift, required 14 CNAs.<br>01/09/2022 had 7 CNAs for 112 residents on the day shift, required 14 CNAs.<br>01/10/2022 had 9 CNAs for 112 residents on the day shift, required 14 CNAs.<br>01/11/2022 had 10 CNAs for 112 residents on the day shift, required 14 CNAs.<br>01/12/2022 had 10 CNAs for 112 residents on the day shift, required 14 CNAs.<br>01/13/2022 had 10 CNAs for 113 residents on the day shift, required 14 CNAs.<br>01/14/2022 had 7 CNAs for 111 residents on the day shift, required 14 CNAs.<br>01/15/2022 had 6 CNAs for 108 residents on the day shift, required 13 CNAs.<br>01/16/2022 had 6 CNAs for 108 residents on the day shift, required 13 CNAs.<br>01/17/2022 had 8 CNAs for 107 residents on the day shift, required 13 CNAs.<br>01/18/2022 had 11 CNAs for 106 residents on the day shift, required 13 CNAs.<br>01/19/2022 had 12 CNAs for 104 residents on the day shift, required 13 CNAs.<br>01/21/2022 had 8 CNAs for 104 residents on the day shift, required 13 CNAs.<br>01/22/2022 had 10 CNAs for 104 residents on the day shift, required 13 CNAs. | S 560 | program, Text message campaigns.<br>The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for two months and then quarterly.<br>The results of Resident Council minutes as well as recruitment data will be reviewed by the Administrator or designee at the quarterly QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061522 | A. BUILDING: _____ B. WING _____ | C 07/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEACREST REHABILITATION AND HEALTHCA | 1001 CENTER ST LITTLE EGG HARBOR TW, NJ 08087 |

| (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 3<br>01/23/2022 had 8 CNAs for 105 residents on the day shift, required 13 CNAs.<br>01/24/2022 had 9 CNAs for 105 residents on the day shift, required 13 CNAs.<br>01/25/2022 had 11 CNAs for 105 residents on the day shift, required 13 CNAs.<br>01/26/2022 had 11 CNAs for 105 residents on the day shift, required 13 CNAs.<br>01/27/2022 had 11 CNAs for 106 residents on the day shift, required 13 CNAs.<br>01/29/2022 had 6 CNAs for 104 residents on the day shift, required 13 CNAs.<br>01/04/2022 had 6 CNAs for 106 residents on the night shift, required 8 CNAs.<br>01/15/2022 had 7 CNAs for 108 residents on the night shift, required 8 CNAs.<br>01/18/2022 had 6 CNAs for 106 residents on the night shift, required 8 CNAs.<br><br>During an interview on 07/07/2022 at 5:09 PM, the Administrator stated the facility strived to staff based on the mandate. He stated the facility recently increased its hourly rate to attract more employees. Per the Administrator, the facility was continuing to make recruitment efforts and had contracts with different staffing agencies. The Administrator added that the facility introduced incentives such as cash coupons in an effort to keep staff. He concluded he was of the impression they were doing their best at keeping the facility fully staffed and that residents' care had not suffered in any capacity. | S 560 | | |

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 315218 Y1 | A. Building<br>B. Wing Y2 | 8/3/2022 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEACREST REHABILITATION AND HEALTHCARE CENTER | 1001 CENTER ST<br>LITTLE EGG HARBOR TW, NJ 08087 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix F0656 | Correction | ID Prefix F0689 | Correction | ID Prefix | Correction |
| Reg. # 483.21(b)(1) | Completed | Reg. # 483.25(d)(1)(2) | Completed | Reg. # | Completed |
| LSC | 08/03/2022 | LSC | 08/03/2022 | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |
|---|---|
| 7/8/2022 | ☐ YES ☐ NO |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 061522 Y1 | A. Building<br>B. Wing Y2 | 8/3/2022 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEACREST REHABILITATION AND HEALTHCARE CENTER | 1001 CENTER ST<br>LITTLE EGG HARBOR TW, NJ 08087 |

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 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 8:39-5.1(a) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 08/03/2022 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

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

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 7/8/2022 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |