STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING _____ B. WING _____	C 08/02/2024

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

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ160087, NJ160601, NJ160749, NJ165218, NJ165918, NJ168841, NJ169307, NJ170964, NJ171424, NJ171789, NJ171790, NJ173699 Survey Date: 08/02/2024 Census: 146 Sample: 29 plus 3 closed 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.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified	F 636		8/5/24

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

Electronically Signed | 08/12/2024

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 636	Continued From page 1	F 636		

by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission,

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F 636	Continued From page 2 excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to identify, document, and transmit on the Minimum Data Set (MDS) an assessment tool used to facility resident care, a resident's diagnosis of [redacted] This deficient practice was identified for 1 of 27 residents (Resident # 72) reviewed for MDS. This deficient practice was evidenced as follows: On 07/29/2024 at 9:47 AM, the surveyor observed Resident #72 self-propelling in their wheelchair (w/c) around the [redacted] unit. The surveyor observed the resident had [redacted]. On 07/31/2024 at 12:52 PM, the Licensed Practical Nurse (LPN) stated that Resident # 72's [redacted] were NJ Ex Order 26.4(b)(1). The LPN further stated that the resident had this diagnosis and [redacted] for three years. A review of the Admission Record documented diagnoses which included but were not limited to; [redacted] (NJ Ex Order 26.4(b)(1) [redacted] personal history of NJ Ex Order 26.4(b)(1) dated	F 636	Resident #72□s MDS, Section M1040 D with an assessment reference date of [redacted] were modified to accurately reflect the resident□s status. Resident #72 was reviewed with [redacted] related to cited event noted. The DON/designee reviewed MDS□ completed in the last 30 days on residents with skin conditions to validate the accuracy of coding section M1040D. Findings were addressed. The director of nursing/designee re-educated the U.S. FOIA (b) (6) on identifying, and accurately documenting/coding the MDS to include but not limited to section M1040 D prior to timely submission. An audit of 3 residents that had MDS□ submitted will be conducted to validate accuracy of coding skin conditions will be completed by the DON/designee. Modifications will be completed for the findings. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Director of Nurses/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance	

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F 636	Continued From page 3 NJ Ex Order 26.4(b)(1), and unspecified NJ Ex Order 26.4(b)(1). A review of the resident-centered, on-going care plan included a focus area of NJ Ex Order 26.4(b)(1) r/t (related to) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the Annual MDS dated NJ Ex Order 26.4(b)(1), included Section M1040 D. NJ Ex Order 26.4(b)(1) other than NJ Ex Order 26.4(b)(1) (e.g. NJ Ex Order 26.4(b)(1)) and had a documented response of "No". A review of the Weekly NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(b)(1), within the 7 day look back period of the Annual MDS, documented Resident # 72 had NJ Ex Order 26.4(b)(1) other than NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the MDS dated NJ Ex Order 26.4(b)(1), included Section M1040 D. NJ Ex Order 26.4(b)(1) other than NJ Ex Order 26.4(b)(1) (e.g. NJ Ex Order 26.4(b)(1)) and had a documented response of "No". A review of the Weekly NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(b)(1) within the 7 day look back period of the MDS, documented Resident # 72 had an NJ Ex Order 26.4(b)(1) other than NJ Ex Order 26.4(b)(1) A review of the MDS dated NJ Ex Order 26.4(b)(1), included Section M1040 D. NJ Ex Order 26.4(b)(1)) other than NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) (e.g. NJ Ex Order 26.4(b)(1)) and had a documented response of "No". A review of the Weekly NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(b)(1), within the 7 day look back period of the MDS, documented Resident # 72 had an NJ Ex Order 26.4(b)(1) other than NJ Ex Order 26.4(b)(1). On 08/01/24 at 8:38 AM, during an interview with the surveyor, the U.S. FOIA (b) (6) stated that she would obtain her resident information from areas such as the progress notes, the staff, the medication and treatment administration records,	F 636	is sustained.	

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F 636	Continued From page 4 and [NJ Ex Order 26.4(b)(1)]. She further stated that [NJ Ex Ord] [redacted] should have been documented on the MDS to reflect accurate care of the resident. A review of the facility provided MDS Coordinator Job Description undated, included but was not limited to; Purpose " ... to conduct and coordinate the development and completion of the resident assessment in accordance with the requirements of this state and the policies and goals of this Center." Care Plan and Assessment Function included but was not limited to; ensure all members of the assessment team are aware of the importance of completeness and accuracy ... On 08/01/2024 at 8:30 AM, the above concern was presented to the facility administrative team. On 08/02/2024 at 9:47 AM, the administrative team acknowledged the concerns with the MDS accuracy but had no additional information to provide regarding Resident # 72. NJAC 8:39-11.1, 11.2	F 636		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments.	F 640		8/5/24

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(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:

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F 640	Continued From page 6 Based on interview, record review, and review of facility documentation, it was determined that the facility failed to complete and transmit NJ Ex Order 26.4 in facility Minimum Data Set (MDS) an assessment tool, for 1 of 1 resident (Resident # 16) reviewed for MDS record over 120 days old. The deficient practice was evidenced by the following: A review of the Admission Record revealed Resident # 16 was admitted with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted]) and NJ Ex Order 26.4(b)(1) [redacted] . A review of the progress notes revealed a note dated NJ Ex Order 26.4(b)(1) at 16:24 (4:24 PM), the resident was noted sitting in their wheelchair and was NJ Ex Order 26.4(b)(1) The resident was taken to their room and was noted NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Resident # 16's code status request was for NJ Ex Order 26.4(b)(1) and no hospitalization. The resident was NJ Ex Order 26.4(b)(1) at 4:15 PM. A review of the MDS' revealed that there was no MDS completed or transmitted to depict Resident # 16's NJ Ex Order in the facility. On 08/01/24 at 8:35 AM, during an interview with the surveyor, the U.S. FOIA (b) (6) was asked about Resident # 16's NJ Ex Order in the facility. The U.S. FOIA (b) (6) acknowledged it had not been completed or transmitted but should have been completed and transmitted timely. The U.S. FOIA [redacted] stated it was important to keep the resident information accurate. A review of the facility provided MDS Coordinator Job Description undated, included but was not limited to; Purpose "The primary purpose of your	F 640	Resident #16 no longer resides at the facility. Resident #16□s MDS assessment was completed to reflect NJ Ex Order in the facility and transmitted to the CMS system. The DON/designee reviewed past residents for the last 30 days that should have had a death in the facility MDS assessment transmitted to validate completion. Findings were addressed. The director of nursing/designee re-educated the U.S. FOIA (b) (6) on timely completion and submission of death in facility MDS assessments. An audit of 3 residents that that should have a death in the facility MDS assessment transmitted will be completed by the MDS Coordinator/designee. Findings will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Director of Nurses/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

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F 640	Continued From page 7 job position is to conduct and coordinate the development and completion of the resident assessment in accordance with the requirements of this state and the policies and goals of this Center." Care Plan and Assessment Function "ensure that a complete resident assessment is conducted within fourteen days of a significant change in the resident's condition." A review of the facility provided policy, "MDS Completion and Submission Timeframes" revised October 2023, included but was not limited to; "Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes." "1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted ... in accordance with current federal and state guidelines." On 08/01/2024 at 12:30 PM, the above concern was addressed with the facility administrative team. The facility had no additional information to provide.	F 640		
F 656 SS=D	NJAC 8:39-11.2 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §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	F 656		8/5/24

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F 656	Continued From page 8	F 656		

assessment. The comprehensive care plan must describe the following -
(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
(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).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(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.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of pertinent facility documentation it

Resident #115 was reviewed by the licensed nurse, and there were [redacted]

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F 656	Continued From page 9 was determined that the facility failed to provide treatment and care to address the resident's NJ Ex Order 26.4(b)(1) needs that were in accordance with professional standards of practice that were based on the comprehensive assessment, person-centered care plan and the resident's choice. The deficient practice was identified for 1 of 4 residents reviewed for NJ Ex Order 26.4(b)(1). The deficient practice was evidenced by the following: On 07/29/2024 at 10:30 AM during the initial tour, the surveyor observed Resident # 115 in the hallway in his/her wheelchair. He/she had a NJ Ex Order [redacted] observed on his/her NJ Ex Order 26.4(The NJ Ex Orde was located outside of his/her NJ Ex Order 2 On 07/30/2024 at 11:57 AM, the surveyor observed Resident # 115 in the hallway in his/her wheelchair. He/she had a NJ Ex Order 26.4(b)(1) observed on his/her NJ Ex Order 26 . The NJ Ex Orde was located outside of his/her NJ Ex Order 2 On the same date at 12:45 PM, the surveyor observed Resident # 115 in his/her wheelchair in the day room eating lunch. He/she had the NJ Ex Order [redacted] observed near the NJ Ex Order 26.4(b) . The NJ Ex Orde was located outside of his/her NJ Ex Order 2 A review of the physician's orders located in Resident # 115's Electronic Medical Record (EMR) did not reveal an order for Resident # 115 to NJ Ex Order 26.4(b)(1). A review of Resident # 115's diagnoses located in the EMR revealed that he/she had diagnoses of but not NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1) [redacted]	F 656	NJ Ex Order 26.4(b)(1) related to the cited event. Resident #115 orders and care plan remain in place for the NJ Ex Orde to the NJ Ex [redacted] The DON/designee conducted an audit of residents who utilize splints to validate that the physician orders and care plans are in place to reflect the resident's status and person-centered needs. Findings were addressed. The director of nursing/designee re-educated licensed nurses to include Unit Managers on the need to obtain orders and have comprehensive person-centered care plans in place that reflect resident preferences and needs to include the use of devices such as splints. The DON/designee will conduct an audit of 3 residents that utilize splints to validate physician orders and that comprehensive person-centered care plans are in place to reflect resident preferences and needs to include the use of splints. Findings will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Director of Nurses/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

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NJ Ex Order 26.4(b)(1)

A review of Resident # 115's Care Plan located in the EMR revealed that he/she did not have a care plan focus or intervention for the NJ Ex Order

On 07/30/2024 at 1:26 PM during an interview with the surveyor, Licensed Practical Nurse (LPN) # 1 said that Resident # 115 chooses to NJ Ex Orde the NJ Ex Order 26.4(b)(1). She said that it was from a prior hospital admission.

Another review of Resident # 115's Care Plan revealed a new intervention that revealed, "I NJ Ex Orde to the NJ Ex Order 26.4(b)(1) when out of bed." The intervention was initiated on NJ Ex Order 26.4(b)(1) after the surveyor's original review of the Care Plan.

Another review of Resident # 115's physician's orders revealed a new order that revealed, "Apply NJ Ex Order 26.4(b)(1) in the morning and remove in the evening every day and evening shift." The order was added on NJ Ex Order 26.4b1 at 20:31 (8:31 PM).

On 07/31/2024 at 9:32 AM during an interview with the surveyor, Unit Manager Licensed Practical Nurse (UMLPN) # 1 replied, "No, I have no reason. Going through the chart, it was on [his/her] chart from the previous stay and I do know NJ Ex NJ Ex Order 26.4 ." when the surveyor asked if there was a reason the order and care plan were input yesterday. The UMLPN # 1 replied, "The day he arrived. One hundred percent." when the surveyor asked when the NJ Ex Order should have been ordered and care planned.

On 08/01/2024 at 12:29 PM during an interview with the U.S. FOIA (b) (6)), the surveyor

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 656	Continued From page 11 asked if a resident entered the facility and chose to use a [NJ Ex Order 26.4(b)] or [NJ Ex Order 2] should there be an order and care plan for it. The [U.S. FOIA] replied, "Yes." Further, the surveyor asked when the order and care plan should be initiated. The [U.S. FOIA] replied, "Upon arrival of the [NJ Ex Order 2] It should be care planned and an order to be put in." A review of the facility policy titled, "Care Plans, Comprehensive Person-Centered" with a revised date of March 2022 revealed under, "Policy Interpretation and Implementation that, "2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission." A review of the facility policy titled, "Range of Motion (ROM) Devices" dated March 2022 revealed under "Procedure" that, "2. When a ROM device is to be utilized, the primary physician or consulting physician will provide orders specifying the type of device, the frequency of application, and the duration of application. a. If applicable, the physician's order will specify the don and doff times for the deice to be applied and removed." and "6. The resident's care plan will include measurable goals and objectives as well as resident-specific interventions for the use of ROM devices." NJAC § 8:39-27.1 (a)	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		8/5/24

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F 690	Continued From page 12 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation it was determined that the facility failed to provide appropriate and sufficient care based upon	F 690	Resident #73 was reviewed by the licensed nurse, and there were [redacted] related to the cited event. Residents 73□s NJ Ex Order 26.4(b)(1)	

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F 690	Continued From page 13 current standards of practice and the resident's care plan by specifically having a NJ Ex Order 26.4(b)(1) [redacted] in contact with the floor and unsecured to the bed frame and failing to document NJ Ex Order 26.4(b)(1) on the treatment administration record (TAR) as ordered. The deficient practice was identified for 1 of 1 residents (Resident #73) investigated for NJ Ex Order 26.4 [redacted] The deficient practice was evidenced by the following: A review of Resident # 73's Minimum Data Set, an assessment tool dated NJ Ex Order 26.4(b)(1) located in the Electronic Medical Record revealed he/she had an NJ Ex Order 26.4(b)(1). A review of Resident # 73's Electronic Medical Record (EMR) revealed that he/she was diagnosed with but not limited to NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1). A review of Resident # 73's physician's orders located in the EMR revealed that he/she had orders to measure NJ Ex Order 26.4(b)(1). A review of Resident # 73's Care Plan located in the EMR revealed a focus that Resident # 73 had an NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(initiated on NJ Ex Order 26.4(b)(1). The focus revealed an intervention to, "Monitor/record/report PRN [as needed] s/sx [signs and symptoms] NJ Ex Order 26.4(b)(1) [redacted]." The intervention was initiated on NJ Ex Order 26.4(b)(1). A review of Resident # 73's Treatment Administration Record located in the EMR	F 690	NJ Ex O was attached to the bed frame to avoid coming in contact with the floor. All residents with urinary catheter drainage bags can be affected. All nursing staff was re-educated on ensuring proper placement of urinary catheter drainage bags. All nursing staff were re-educated on proper urinary output documentation. Facility completed a facility wide audit of all residents utilizing a urinary catheter drainage bag, ensuring proper placement and proper output documentation. The director of nursing or designee will conduct weekly audits x12 weeks on x4 residents, utilizing urinary catheter drainage bags, ensuring proper placement and proper output documentation. The contents of the audit above will be reported by the administrator or his designee and reviewed at the quarterly QA meeting for 6 months with suggested recommendations by the committee.	

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F 690	Continued From page 14 revealed an order to measure [NJ Ex Order 26.4(b)(1)] every shift, document [NJ Ex Order 26.4(b)(1)] in [NJ Ex Order 26.4(b)(1)]. The order had a start date of [NJ Ex Order 26.4(b)(1)]. The following dates and times were blank revealing [NJ Ex Order 26.4(b)(1)] in [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4] - Night [NJ Ex Order 26.4] - Evening, Night [NJ Ex Order 26.4] - Night [NJ Ex Order 26.4] - Evening [NJ Ex Order 26.4] - Night [NJ Ex Order 26.4] - Evening [NJ Ex Order 26.4] - Evening [NJ Ex Order 26.4] - Night [NJ Ex Order 26.4] - Night On 07/30/2024 at 8:25 AM while touring the unit, the surveyor observed Resident # 73 in bed. At that time, the surveyor observed the [NJ Ex Order 26.4(b)(1)] in contact with the floor. The plastic securement hook was not attached to the bed frame. On 08/01/2024 at 12:29 PM, during an interview with the U.S. FOIA (b) (6)), the surveyor asked if a resident had an [NJ Ex Order 26.4(b)(1)], how should the [NJ Ex Order 26.4(b)(1)] be secured when the resident is in bed. The [U.S. FOIA] replied, "...It should be [NJ Ex Order 26.4(b)(1)] to the non-moveable portion of the bed." Further, the surveyor asked should the [NJ Ex Order 26.4(b)(1)] be in contact with the floor. The [U.S. FOIA] replied, "No." Lastly, the surveyor asked if a resident has an order to measure [NJ Ex Order 26.4(b)(1)], would you consider it administered if the Treatment Administration Record is blank. The [U.S. FOIA] replied, "No." A review of the facility policy titled, "Catheter Care, Urinary" revised August 2022 revealed	F 690		

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F 690	Continued From page 15 under "Infection Control" that, "2. Be sure the catheter tubing and drainage bag are kept off the floor." Also, the policy revealed under, "Input/Output" that, "2. Follow the facility procedure for measuring and documenting input and output." NJAC § 8:39-27.1 (a)	F 690		
F 695 SS=D	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 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, record review and review of facility documentation, it was determined that the facility failed to ensure a resident's NJ Ex Order 26.4(b)(1) system was stored to protect it from the environment. This deficient practice was identified for 1 of 2 residents (Resident #118) reviewed for NJ Ex Order 26.4(b)(1) and was evidenced as follows. On 07/29/2024 at 10:29 AM, the surveyor observed Resident #118 in a NJ Ex Order 26.4(b)(1) wheelchair (w/c) in the unit day room. Resident #118 had a NJ Ex Order 26.4(b)(1) on the back of the w/c and was wearing a NJ Ex Order 26.4(b)(1) as an NJ Ex Order 26.4(b)(1).	F 695	Resident #118's NJ Ex Order 26.4(b)(1) was changed, labeled and dated by the licensed nurse on 7/30/2024. A NJ Ex Order 26.4(b)(1) was put in place on Resident #118's wheelchair to store the NJ Ex Order 2 when NJ Ex Order 26. is not in use. Resident #118 was reviewed with NJ Ex Order 26.4b1 as ordered and NJ Ex Order 26.4b1 related to the cited event. The U.S. FOIA (b) (6) was re-educated regarding the need to validate that oxygen is administered as ordered, portable oxygen tanks are appropriately functioning, and oxygen tubing is stored in a protective container when not in use. The DON/designee conducted rounds on	8/5/24

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F 695	Continued From page 16 On 07/30/2024 at 12:49 PM, the surveyor observed Resident #118 again in the [redacted] unit day room. Resident #118 was not wearing a [redacted]. The surveyor observed the back of the w/c with the NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(1) the top of the NJ Ex Order 26.4(b)(1). The [redacted] was exposed to the environment and not in any NJ Ex Order 26.4(b)(1). A review of the electronic medical record (EMR) for Resident #118 revealed an Admission Record with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted]), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) A review of the Admission Minimum Data Set (MDS) an assessment tool used to facilitate resident care dated NJ Ex Order 26.4(b)(1), documented the resident scored [redacted] out of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had NJ Ex Order 26.4(b)(1). The MDS further revealed that Resident #118 used [redacted] The Order Summary Report revealed a physician's order dated NJ Ex Order 26.4(b)(1), for NJ Ex Order 26.4(b)(1) [redacted] as needed for NJ Ex Order 26.4(b)(1)) or NJ Ex Order 26.4(b)(1) [redacted] or below as needed. A review of the resident-centered, on-going resident Care Plan included a focus area of NJ Ex Order 26.4(b)(1) status ... and included an intervention to administer NJ Ex Order 26.4(b)(1) treatments. On 07/31/2024 at 10:12 AM, the surveyor observed Resident #118 in the NJ Ex Order 26.4b1 unit day room. The resident was wearing the NJ Ex Order 26.4(b)(1) [redacted] system, but the NJ Ex Order 26.4(b)(1)	F 695	7/30/2024 and 7/31/2024 for residents with oxygen orders to validate that oxygen was administered as ordered, portable oxygen tanks were functioning appropriately, and oxygen tubing was stored in a protective container when not in use. No further findings were noted. The licensed nurses were re-educated on the need to validate that oxygen is administered as ordered, portable oxygen tanks are appropriately functioning, and oxygen tubing is stored in a protective container when not in use. An audit to include 3 rounds will be conducted by the DON/Designee on nursing units at different times of the day to validate those residents with oxygen orders had oxygen administered as ordered, portable oxygen tanks were functioning appropriately as applicable, and oxygen tubing was stored in a protective container when not in use. Findings will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Director of Nursing/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

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F 695	Continued From page 17 was set at [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b) (6)]) was at the nurse's desk and was asked to come and observe the [NJ Ex Order 26.4]. The [U.S. FOIA (b) (6)] acknowledged that the [NJ Ex Order 26.4(b)(1)] was set at the wrong [NJ Ex Order 26.4(b)(1)] and also observed there was something wrong with the [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b) (6)] removed the [NJ Ex O] from the resident. The resident took the [NJ Ex] and placed it under their w/c cushion. The [NJ Ex Order 26.4(b)(1)] was changed for a new one. At that time, the [U.S. FOIA (b) (6)] was asked about how the [ ] should be stored when not in use. The [U.S. FO] [ ] stated that the [NJ Ex O] should be kept in a plastic bag to protect it from getting "dirty". The surveyor showed the [U.S. FOIA (b) (6)] the [NJ Ex] not in a [NJ Ex Order 26.4(b)(1)] on 07/30/2024. The [U.S. FOIA (b) (6)] acknowledged that was not the correct way to store the [NJ Ex Or] A review of the facility provided policy, "Oxygen & Nebulizer Use-Infection Control" adopted August 2021, included but was not limited to; "Purpose. The purpose of this procedure is to guide prevention of infection associated with oxygen administration." Steps in the Procedure ... "8. Keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use." On 08/01/2024 at 12:30 PM, the above information was provided to the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)]). No additional information was provided by the facility.	F 695		
F 740 SS=D	NJAC 8:39-19.4(c), 27.1(a) Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services.	F 740		8/5/24

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F 740	Continued From page 18 Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of pertinent facility documentation, it was determined that the facility failed to consistently monitor and document behaviors of residents on NJ Ex Order 26.4(b)(1) medications per the physician's orders and the resident-centered Care Plan. This deficient practice was identified for 2 of 7 residents (Resident # 105 and # 117) reviewed for behaviors and was evidenced by the following: 1.) On 07/29/24 at 10:13 AM, the surveyor observed Resident # 105 in the NJ Ex Order 26.4b1 unit day room. Resident # 105 was holding a blanket; their eyes were closed, and the resident did not respond to the surveyor when the surveyor greeted the resident. On 08/01/24 at 8:12 AM, the Certified Nursing Assistant (CNA) stated she did care for Resident # 105 too often and was not sure of the resident's NJ Ex Order 26.4(b)(1) On 08/01/24 at 8:18 AM, the U.S. FOIA (b) (6)) stated Resident #105 had behaviors of NJ Ex Order 26.4(b)(1) staff during care. She stated the resident would have NJ Ex Order 26.4(b) charting documented every shift and was seen by	F 740	Resident #105 was reviewed with of NJ Ex Order 26.4(b)(1). Resident #105 was reviewed by the clinical provider with no order changes related to the cited event. Resident #105's TAR for the last 3 days was reviewed with consistent documentation in place related to NJ Ex Order 26.4(b) status and side effect monitoring. Resident #117 was reviewed with NJ Ex Order 2 . Resident #117 was reviewed by the clinical provider with no order changes related to the cited event. Resident #117's TAR for the last 3 days was reviewed with consistent documentation in place related to NJ Ex Order 26.4b1 status and side effect monitoring. Residents on psychotropic medications were reviewed to validate that behavior and side effects monitoring were in place and documented as ordered and care planned for the last 7 days. Findings were addressed. The licensed nurses were re-educated on the need to document behaviors and the monitoring of potential side effects that	

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F 740	Continued From page 19 NJ Ex Order 26.4(b)(1) The U.S. FOIA (b) (6) stated there should never be blank areas on any Medication Administration Record (MAR) or Treatment Administration Record (TAR). A review of the Admission Record revealed that Resident # 105 was admitted with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1) A review of the Order Summary Report active orders as of 08/01/2024, included but were not limited to; an order dated NJ Ex Order 26.4(b)(1), for NJ Ex Order 26.4(b)(1) [redacted] give 2 capsules by mouth two times a day related to NJ Ex Order 26.4(b)(1); dated NJ Ex Order 26.4(b)(1), for NJ Ex Order 26.4(b)(1) give 1 tablet by mouth one time a day for NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) give 1 tablet by mouth at bedtime for NJ Ex Order 26.4(b)(1). There was an order dated NJ Ex Order 26.4(b)(1), "NJ Ex Order 26.4(b)(1)/Intervention monitor for NJ Ex Order 26.4(b)(NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) with intervention codes may include ... 1. Redirection 2. Direct supervision 3. Activity 4. Toilet 5. Food/fluid offered 6. Position change 7. Other intervention (specify in progress notes) 8. Medication "every shift for NJ Ex Order 26.4(b) [redacted] A review of the resident-centered, on-going care plan included but was not limited to the following: A focus area for the use of NJ Ex Order 26.4(b)(1) medication, initated NJ Ex Order 26.4(b)(1) with an intervention to observe for effectiveness and side effects initiated NJ Ex Order 26.4(b)(1). A focus area for the use of NJ Ex Order 26.4(b)(1) medication, initated NJ Ex Order 26.4(b)(1) with interventions	F 740	may be caused by using the psychotropic medication as indicated per clinical provider orders and resident care plan. An audit of 3 residents on psychotropic medications will be conducted by the DON/Designee to validate that monitoring and documentation is in place for behaviors and potential side effects that may be caused by the use of psychotropic medications. Findings will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Director of Nursing/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

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F 740	Continued From page 20	F 740		

to observe for effectiveness and side effects, and to monitor/document/report to physician ongoing s/sx (signs/symptoms) of NJ Ex Order 26.4(b)(1) unaltered by NJ Ex Order 26.4(b)(1) medication, or worsening s/sx of NJ Ex Order 26.4(b)(1) initated NJ Ex Order 26.4(b)(1).

A focus area for the use of NJ Ex Order 26.4(b)(1) medication r/t (related to) NJ Ex Order 26.4(b) management, NJ Ex Order 26.4(b)(1) initated NJ Ex Order 26.4(b)(1) with interventions to observe for effectiveness and side effects, and to report to nurse possible medication side effects ... initated NJ Ex Order 26.4(b)(1).

A focus area of being resistive to care related to NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1 initiated NJ Ex Order 26.4(b)(1) with interventions to allow the resident to make decisions initated NJ Ex Order 26.4(b)(1); encourage participation initated NJ Ex Order 26.4(b)(1); provide consistency in care initated NJ Ex Order 26.4(b)(1); and to provide NJ Ex Order 26.4(b)(1) when needed initated NJ Ex Order 26.4(b)(1)

A review of the TARs revealed the following:

Dated NJ Ex Order 26.4(b)(1), an order dated NJ Ex Order 26.4(b)(1), "Monitor for changes in NJ Ex Order 26.4(b)(1 every shift". The TAR revealed two blank areas where monitoring was not documented as being completed.

Dated NJ Ex Order 26.4(b)(1) "Monitor for changes in NJ Ex Order 26.4(b)(1 every shift". The TAR revealed one blank area where monitoring was not documented as being completed.

Dated NJ Ex Order 26.4(b)(1), "Monitor for changes in NJ Ex Order 26.4(b)(1 every shift". The TAR revealed three blank areas and two shifts marked "NO" which indicated the monitoring was not documented as

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SEACREST REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 740	Continued From page 21 being completed. The TAR legend and codes did not include "NO". Dated [redacted]/Intervention monitor for [redacted] and include intervention codes. Five shifts documented [redacted] but failed to document any interventions. Nine shift documented "X" which indicated the monitoring was not documented as being completed. The TAR did not list "X" in the codes or legends. 2.) On 07/30/24 at 9:52 AM, the surveyor observed Resident # 117 in the [redacted] unit day room holding a [redacted] and having the [redacted] on the table. The resident smiled when the surveyor spoke to them but did not respond. On 07/31/24 at 10:18 AM, the surveyor observed Resident # 117 in the day room sitting in a wheelchair at a table with other residents. The CNA was assisting the resident with looking at pictures. The CNA stated that the resident was [redacted] when they get [redacted] and likes to keep the [redacted] with them. A review of the Admission Record revealed Resident # 117 had diagnoses which included but were not limited to; [redacted], [redacted], and [redacted]. A review of the Order Summary Report included an order dated [redacted]; dated [redacted]; and dated [redacted] related to [redacted]. There was an order dated [redacted]/Intervention Monitor for ([redacted]) ie: [redacted]	F 740		

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F 740	Continued From page 22 Intervention Codes ... 1. Redirection 2. Direct supervision 3. Activity 4. Toilet 5. Food/fluid offered 6. Position change 7. Other intervention (specify in progress notes) 8. Medication "every shift for NJ Ex Order 26.4(b management". A review of the resident-centered, on-going care plan included the following: A focus area for the use of NJ Ex Order 26.4(b)(1) medication, initated NJ Ex Order 26.4(b)(1) with interventions observe for effectiveness and side effects, monitor/document/report to physician ongoing s/sx of NJ Ex Order 26.4(b)(1) unaltered by NJ Ex Order 26.4(b)(1) medication, or worsening s/sx of NJ Ex Order 26.4(b)(1) and report to nurse possible medication side effects initiated NJ Ex Order 26.4(b)(1) A focus area for use of NJ Ex Order 26.4(b)(1) medication r/t NJ Ex Order 26.4b1, initiated NJ Ex Order 26.4(b)(1) with interventions to observe for effectiveness and side effects, and report to the nurse possible medication side effects initiated NJ Ex Order 26.4(b)(1) A focus area of having the potential to demonstrate NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) ... NJ Ex Order 26.4(b)(1), and will NJ Ex Order 26.4(in other residents NJ Ex Order 26.4(b)(1), initiated NJ Ex Order 26.4(b)(1). Interventions included intervene before NJ Ex Order 26.4(escalates, guide away from NJ Ex Order 26.4(b)(1), engage in conversation, if resident is still NJ Ex Order 26.4(b)(1) approach later , initiated NJ Ex Order 26.4(b)(1). A focus area for use of NJ Ex Order 26.4(b)(1) medication r/t NJ Ex Order 26.4(b)(1), initiated NJ Ex Order 26.4(b)(1) with interventions to observe for effectiveness and side effects, offer to have someone sit with resident when NJ Ex Order 26.4(provide quiet space and	F 740		

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F 740	Continued From page 23	F 740		

reduced stimuli, and report to nurse possible medication side effects initiated [redacted].

A review of the TARs revealed "[redacted] monitor for ([redacted] with Intervention Codes ... 1. Redirection 2. Direct supervision 3. Activity 4. Toilet 5. Food/fluid offered 6. Position change 7. Other intervention (specify in progress notes) 8. Medication "every shift for [redacted] The TARs documented the following:

Dated [redacted], 36 shifts left blank where [redacted] was not completed. One shift marked "N" where [redacted] was not completed. Two shifts marked "X" where [redacted] was not completed. The TAR legend and codes did not include "X" or "N" for the # (number) of [redacted] exhibited.

Dated [redacted], 39 shifts left blank where [redacted] was not completed. Four shifts marked "X" where [redacted] was not completed. The TAR legend and codes did not include "X".

Dated [redacted], 44 shifts left blank where [redacted] was not completed. Ten shifts marked "X" or "N" where [redacted] was not completed. The TAR legend and codes did not include "X" or "N" for the # of [redacted] exhibited.

Dated [redacted], 41 shifts left blank where [redacted] was not completed. Four shifts marked "X" or "N" where [redacted] was not completed. The TAR legend and codes did not include "X" or "N" for the # of [redacted] exhibited.

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Dated [redacted], 11 shifts left blank where [redacted] was not completed. Eight shifts marked "X" where [redacted] was not completed. The TAR legend and codes did not include "X".

On 08/01/24 at 8:47 AM, the [redacted] stated [redacted] was completed and documented on every shift. She stated that there should not be any blank areas because that indicates it was not done.

On 08/02/24 at 10:42 AM, the [redacted] reviewed the TARS with the surveyor. The [redacted] acknowledged that "X" "means it was not done". The [redacted] further stated that the documentation on the TARs should have been done according to the code on the orders and not an "X".

A review of the facility provided policy, "Charting and Documentation" revised July 2017, included but was not limited to; Policy Statement "The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." Policy Interpretation and Implementation "6. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records."

A review of the facility provided policy, "Behavioral Assessment, Intervention and Monitoring" revised March 2019, included but was not limited to; Policy Statement "2. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment." "5. Residents will have minimal

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F 740	Continued From page 25 complications associated with the management of altered or impaired behavior." Assessment "2. As part of the comprehensive assessment, staff evaluate ... a. the resident's usual patterns of cognition, mood and behavior; c. the resident's typical or past responses to stress, fatigue, fear, anxiety, frustration and other triggers." "3. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition ..." "4. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others." Causes Identification "1. The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition ..." Management "10. When medications are prescribed for behavioral symptoms, documentation will include: ... h. monitoring for efficacy and adverse consequences ..."	F 740		
F 758 SS=D	NJAC 8:39-27.1(a) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		8/5/24

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F 758	Continued From page 26 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 758	Resident #105 was reviewed with [redacted]	

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F 758	Continued From page 27 and review of pertinent facility documentation, it was determined that the facility failed to monitor and document potential side effects of NJ Ex Order 26.4(b)(1) medications per physician's orders and the resident-centered Care Plan. This deficient practice was identified for 2 of 5 residents (Resident # 105 and # 117) reviewed for unnecessary medications and was evidenced by the following: 1.) On 07/29/24 at 10:13 AM, the surveyor observed Resident # 105 in the NJ Ex Order 26.4b1 unit day room. Resident # 105 was holding a blanket; their eyes were closed, and the resident did not respond to the surveyor when the surveyor greeted the resident. A review of the Admission Record revealed that Resident # 105 was admitted with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1) A review of the Order Summary Report active orders as of NJ Ex Order 26.4(b)(1), included but were not limited to; an order dated NJ Ex Order 26.4(b)(1) [redacted], for NJ Ex Order 26.4(b)(1) give 2 capsules by mouth two times a day related to NJ Ex Order 26.4(b)(1); dated NJ Ex Order 26.4(b)(1), for NJ Ex Order 26.4(b)(1) give 1 tablet by mouth one time a day for NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) give 1 tablet by mouth at bedtime for NJ Ex Order 26.4(b)(1). There were orders dated NJ Ex Order 26.4(b)(1) to monitor for the following side effects: NJ Ex Order 26.4(b)(1) medications every shift which may include ... NJ Ex Order 26.4(b)(1) [redacted] other (specify in progress notes) every shift side effect codes Y=yes, N=no.	F 758	of NJ Ex Order 26.4(b)(1). Resident #105 was reviewed by the clinical provider with no order changes related to the cited event. Resident #105's TAR for the last 3 days was reviewed with consistent documentation in place related to NJ Ex Order 26.4(b) status and side effect monitoring. Resident #117 was reviewed with [redacted] of NJ Ex Order 26.4(b)(1). Resident #117 was reviewed by the clinical provider with no order changes related to the cited event. Resident #117's TAR for the last 3 days was reviewed with consistent documentation in place related to NJ Ex Order 26.4(b) [redacted] status and side effect monitoring. Residents on psychotropic medications were reviewed to validate that behavior and side effects monitoring were in place and documented as ordered and care planned for the last 7 days. Findings were addressed. The licensed nurses were re-educated on the need to document behaviors and the monitoring of potential side effects that may be caused by using the psychotropic medication as indicated per clinical provider orders and resident care plan. An audit of 3 residents on psychotropic medications will be conducted by the DON/Designee to validate that monitoring and documentation is in place for behaviors and potential side effects that may be caused by the use of psychotropic medications. Findings will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by	

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F 758	Continued From page 28 NJ Ex Order 26.4(b)(1) medications every shift which may include ... NJ Ex Order 26.4(b)(1) [redacted], other (specify in progress notes) every shift side effect codes Y=yes, N=no. NJ Ex Order 26.4(b)(1) medications every shift which may include ... NJ Ex Order 26.4(b)(1) [redacted], other (specify in progress notes) every shift side effect codes Y=yes, N=no. A review of the resident-centered, on-going care plan included but was not limited to the following: A focus area for the use of NJ Ex Order 26.4(b)(1) medication initiated NJ Ex Order 26.4(b)(1), with an intervention to observe for effectiveness and side effects initated NJ Ex Order 26.4(b)(1) A focus area for the use of NJ Ex Order 26.4(b)(1) medication intiated NJ Ex Order 26.4(b)(1) with an intervention to observe for effectiveness and side effects initated NJ Ex Order 26.4(b)(1) A focus area for the use of NJ Ex Order 26.4(b)(1) medication r/t (related to) NJ Ex Order 26.4(b) management initated NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) with interventions to observe for effectiveness and side effects, and to report to nurse possible medication side effects ... initated NJ Ex Order 26.4(b)(1). A review of the Treatment Administration Records (TAR) revealed the following: Dated NJ Ex Order 26.4(b)(1), the side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 48 shifts	F 758	the Director of Nursing/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

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were left blank and 13 shifts documented SE (side effects) as "X". The side effect monitoring of the NJ Ex Order 26.4b1 medication revealed 48 shifts were left blank and 13 shifts documented SE as "X". The side effect monitoring of the NJ Ex Order 26.4b1 medication revealed 48 shifts were left blank and 13 shifts documented SE as "X". The TAR legend and chart codes did not list "X" as an abbreviation for documentation.

Dated NJ Ex Order 26.4(b)(1) the side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 40 shifts were left blank and 5 shifts documented SE (side effects) as "X". The side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 40 shifts were left blank and 5 shifts documented SE as "X". The side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 40 shifts were left blank and 4 shifts documented SE as "X". The TAR legend and chart codes did not list "X" as an abbreviation for documentation.

Dated NJ Ex Order 26.4(b)(1) the side effect monitoring of the NJ Ex Order 26.4b1 medication revealed 44 shifts were left blank and 5 shifts documented SE (side effects) as "X". The side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 44 shifts were left blank and 2 shifts documented SE as "X". The side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 44 shifts were left blank and 2 shifts documented SE as "X". The TAR legend and chart codes did not list "X" as an abbreviation for documentation.

Dated NJ Ex Order 26.4(b)(1), the side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 41 shifts were left blank and 2 shifts documented SE (side effects) as "X". The side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 41 shifts

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were left blank and 2 shifts documented SE as "X". The side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 41 shifts were left blank and 2 shifts documented SE as "X". The TAR legend and chart codes did not list "X" as an abbreviation for documentation.

Dated NJ Ex Order 26.4(b)(1), the side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 11 shifts were left blank and 9 shifts documented SE (side effects) as "X". The side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 11 shifts were left blank and 9 shifts documented SE as "X". The side effect monitoring of the NJ Ex Order 26.4(b)(1) medication revealed 11 shifts were left blank and 9 shifts documented SE as "X". The TAR legend and chart codes did not list "X" as an abbreviation for documentation.

2.) On 07/30/24 at 9:52 AM, the surveyor observed Resident # 117 in the NJ Ex Order 26.4b1 unit day room holding a NJ Ex Order 26.4(b)(1) and having the NJ Ex O on the table. The resident smiled when the surveyor spoke to them but did not respond.

On 07/31/24 at 10:18 AM, the surveyor observed Resident # 117 in the day room sitting in a wheelchair at a table with other residents. The CNA was assisting the resident with looking at pictures. The CNA stated that the resident was NJ Ex Order 26.4(b)(1) when they NJ Ex Order 26.4(b)(and likes to keep the NJ Ex Order 26.4(b)(1) with them.

A review of the Admission Record revealed Resident # 117 had diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1). A review of the Order Summary Report included an order dated NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) give 1

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tablet by mouth two times a day related to NJ Ex Order 26.4 dated NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) give 1 tablet by mouth one time a day for NJ Ex Order 26.4(b)(1) and dated NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) give 1 tablet by mouth three times a day related to NJ Ex Order 26.4(b)(1).

There was a physician order dated NJ Ex Order 26.4(b)(1), to monitor for side effects of NJ Ex Order 26.4(b)(1) medications every shift which may include ... NJ Ex Order 26.4(b)(1) other (specify in progress notes) every shift side effect codes Y=yes, N=no. Document side effects in progress notes.

There were physician's orders dated NJ Ex Order 26.4(b)(1), to monitor for the side effects of:

NJ Ex Order 26.4(b)(1) medications every shift which may include ... NJ Ex Order 26.4(b)(1), other (specify in progress notes) every shift side effect codes Y=yes, N=no.

NJ Ex Order 26.4(b)(1) medications every shift which may include ... NJ Ex Order 26.4(b)(1), other (specify in progress notes) every shift side effect codes Y=yes, N=no.

A review of the resident-centered, on-going care plan included the following:

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A focus area for the use of NJ Ex Order 26.4(b)(1) medication, initiated NJ Ex Order 26.4(b)(1) with interventions observe for effectiveness and side effects initiated NJ Ex Order 26.4(b)(1).
A focus area for use of NJ Ex Order 26.4(b)(1) medication r/t NJ Ex Order 26.4(b management, initiated NJ Ex Order 26.4(b)(1) with interventions to observe for effectiveness and side effects, and report to the nurse possible medication side effects initiated NJ Ex Order 26.4(b)(1).
A focus area for use of NJ Ex Order 26.4(b)(1) medication r/t NJ Ex Order 26. disorder, initated NJ Ex Order 26.4(b)(1) with interventions to observe for effectiveness and side effects initated NJ Ex Order 26.4(b)(1).

A review of the TARs revealed the following:

Dated NJ Ex Order 26.4(b)(1), the side effect monitoring for NJ Ex Order 26.4(b)(1) medications revealed 35 shifts left blank where monitoring was not completed. Two shift marked "X" for the SE. The TAR legend and chart codes did not list "X" as an abbreviation for documentation. There was no documentation of monitoring for the SE of the NJ Ex Order 26.4(b)(1) medication ordered NJ Ex Order 26.4(b)(1)

Dated NJ Ex Order 26.4(b)(1), the side effect monitoring for NJ Ex Order 26.4(b)(1) medications revealed 39 shifts left blank where monitoring was not completed. Five shift marked "X" for the SE. The TAR legend and chart codes did not list "X" as an abbreviation for documentation. There was no documentation of monitoring for the SE of the NJ Ex Order 26.4(b)(1) medication ordered NJ Ex Order 26.4(b)(1).

Dated NJ Ex Order 26.4(b)(1) the side effect monitoring for NJ Ex Order 26.4(b)(1) medications revealed 44 shifts left blank where monitoring was not completed. Two shift marked "X" for the SE. The TAR legend and

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	315218	A. BUILDING _____ B. WING _____	C 08/02/2024

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

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F 758	Continued From page 33	F 758		

chart codes did not list "X" as an abbreviation for documentation. There was no documentation of monitoring for the SE of the [NJ Ex Order 26.4(b)(1)] medication ordered [NJ Ex Order 26.4(b)(1)].

Dated [NJ Ex Order 26.4(b)(1)] the side effect monitoring for [NJ Ex Order 26.4(b)(1)] medications revealed 41 shifts left blank where monitoring was not completed. Two shift marked "X" for the SE. The TAR legend and chart codes did not list "X" as an abbreviation for documentation. There was no documentation of monitoring for the SE of the [NJ Ex Order 26.4(b)(1)] medication ordered [NJ Ex Order 26.4(b)(1)] or the [NJ Ex Order 26.4(b)(1)] medication ordered [NJ Ex Order 26.4(b)(1)].

Dated [NJ Ex Order 26.4(b)(1)] the side effect monitoring of the [NJ Ex Order 26.4(b)(1)] medication revealed 9 shifts documented SE (side effects) as "X". The side effect monitoring of the [NJ Ex Order 26.4(b)(1)] medication revealed 9 shifts documented SE as "X". The side effect monitoring of the [NJ Ex Order 26.4(b)(1)] medication revealed 11 shifts were left blank and 8 shifts documented SE as "X". The TAR legend and chart codes did not list "X" as an abbreviation for documentation.

On 08/01/24 at 8:47 AM, the [U.S. FOIA (b) (6)] stated that there should not be any blank areas on the TAR because that indicated it was not done.

On 08/02/24 at 10:42 AM, the [U.S. FOIA (b) (6)]) reviewed the TARS with the surveyor. The [U.S. FOIA (b)] acknowledged that "X" "means it was not done". The [U.S. FOIA (b)] further stated that the documentation on the TARs should have been done according to the code on the orders and not an "X".

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F 758	Continued From page 34 A review of the facility provided policy, "Charting and Documentation" revised July 2017, included but was not limited to; Policy Statement "The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." Policy Interpretation and Implementation "6. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records." A review of the facility provided policy, "Behavior Assessment, Intervention and Monitoring" revised March 2019, included but was not limited to; Management "10. When medications are prescribed for behavioral symptoms, documentation will include: ... h. monitoring for efficacy and adverse consequences ..." Monitoring "3. Interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment. 4. If antipsychotic medications are used to treat behavioral symptoms, the IDT (interdisciplinary team) will monitor ... a. the IDT will monitor for side effects and complications related to psychoactive medications; for example, lethargy, abnormal involuntary movements, anorexia, or recurrent falling. B. If such symptoms are identified, ... the IDT will adjust the current regiment to try to minimize side effects while maintaining therapeutic effectiveness." NJAC 8:39-27.1(a)	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		8/5/24

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F 812	Continued From page 35 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 7/29/2024 from 09:28 AM to 09:48 AM the surveyor accompanied by the U.S. FOIA (b) (6) [redacted]), observed the following in the kitchen: 1. In the walk-in refrigerator there was raw fish wrapped in plastic wrap with a "use by" date of	F 812	No specific residents were identified. The identified raw fish, frozen pork, 3 bags of frozen corned beef, 11 salad plates, and 2 pitchers of iced tea were discarded. Current residents who receive facility meals have the potential to be affected. Rounds were made on 7/29/2024 with no adverse effects related to cited event noted. An audit was completed by the Food Service Director of food items in the kitchen to validate proper label and dating and that expired items were not on hand. No further findings were noted. The administrator/ designee re-educated the kitchen staff on the need to promptly	

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F 812	Continued From page 36 7/28/2024. The U.S. FOIA (b) removed the fish and stated, "That should have been removed." 2. In the walk-in freezer there was a bag of frozen pork with a "use by" date of 7/10/2024 and three bags of frozen corned beef with a "use by" date of 5/6/2024. The U.S. FOIA (b) removed the items and stated, "They should have all been removed." 3. In the prep refrigerator there were 11 salad plates on two trays wrapped in plastic wrap with no label or date, and 2 pitchers of what the U.S. FOIA (b) identified as iced tea with no label and no date. The U.S. FOIA (b) removed the items and stated, "They were made today but they should be labeled and dated." On 08/01/2024 at 12:30 PM during an interview with the surveyor, the U.S. FOIA (b) (6)) replied "No" when asked if food that is after their "use by" date should still be in the freezer and refrigerator. A review of the facility provided policy "Food Receiving and Storage" with a revised date of November 2022 revealed under the " Policy Statement" that, "Food shall be received and stored in a manner that complies with food handling practices." The policy also revealed under section "Refrigerator/Freezer Storage" that, " All foods stored in the refrigerator or freezer are covered, labeled and dated ("use by") date. N.J.A.C. 8:39-17.2(g)	F 812	label and date food items and to timely discard expired items per facility policy. An audit of 3 kitchen rounds will be conducted by the Administrator/designee to validate that food items are properly labeled, and dated and that expired items are not on hand. Findings will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

New Jersey Department of Health

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint: # 160087, 160749, 165218, 168841, 165918 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Findings include: A.) 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	Facility will continue its best faith effort to remain in compliance with mandatory access to care. No residents were identified Residents of the facility have the potential to be affected The Director of Nursing, Human Resource Director, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for the next day, and staffing for the upcoming week. The facility has developed a Culture Committee focused on recruitment and retention of staff along with customer service and the employee experience. The facility has implemented	8/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/12/24

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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. 1. For the week of Complaint staffing from 12/04/2022 to 12/10/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 evening shifts as follows: -12/04/22 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -12/05/22 had 9 CNAs for 105 residents on the day shift, required at least 13 CNAs. -12/06/22 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -12/07/22 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/08/22 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/09/22 had 7 CNAs for 104 residents on the day shift, required at least 13 CNAs. -12/10/22 had 8 CNAs for 104 residents on the	S 560	the Care Champion Program to mentor new employees which has been proven to raise retention rates. The facility participates in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes. 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, in-house Nurse Aide Training and Competency Evaluation Program, Text message campaigns. 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. The results of the monthly Resident Council minutes as well as recruitment data will be reviewed by the Administrator or designee at the quarterly QAPI meeting until the facility is able to sustain the staffing requirements.	

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day shift, required at least 13 CNAs.
-12/10/22 had 7 total staff for 104 residents on the evening shift, required at least 10 total staff.

2. For the week of Complaint staffing from 01/15/2023 to 01/21/2023, the facility was efficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows:

-01/15/23 had 11 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-01/16/23 had 11 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-01/17/23 had 14 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-01/18/23 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-01/19/23 had 11 CNAs for 126 residents on the day shift, required at least 16 CNAs.
-01/20/23 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs.
-01/20/23 had 8 CNAs to 18 total staff on the evening shift, required at least 9 CNAs.
-01/21/23 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs.

3. For the 2 weeks of Complaint staffing from 03/19/2023 to 04/01/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 4 of 14 overnight shifts as follows:

-03/19/23 had 9 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-03/20/23 had 5 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-03/21/23 had 7 CNAs for 123 residents on the day shift, required at least 15 CNAs.

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S 560	Continued From page 3 -03/22/23 had 8 CNAs for 120 residents on the day shift, required at least 15 CNAs. -03/22/23 had 8 total staff for 120 residents on the overnight shift, required at least 9 total staff. -03/23/23 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. -03/24/23 had 6 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/25/23 had 7 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/25/23 had 5 CNAs to 12 total staff on the evening shift, required at least 6 CNAs. -03/26/23 had 6 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/26/23 had 6 total staff for 119 residents on the overnight shift, required at least 8 total staff. -03/27/23 had 6 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/28/23 had 8 CNAs for 119 residents on the day shift, required at least 15 CNAs. -03/29/23 had 8 CNAs for 123 residents on the day shift, required at least 15 CNAs. -03/30/23 had 8 CNAs for 123 residents on the day shift, required at least 15 CNAs. -03/31/23 had 7 CNAs for 123 residents on the day shift, required at least 15 CNAs. -03/31/23 had 8 total staff for 123 residents on the overnight shift, required at least 9 total staff. -04/01/23 had 8 CNAs for 126 residents on the day shift, required at least 16 CNAs. -04/01/23 had 8 total staff for 126 residents on the overnight shift, required at least 9 total staff. 4. For the week of Complaint staffing from 06/18/2023 to 06/24/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -06/18/23 had 10 CNAs for 114 residents on the	S 560		

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S 560	Continued From page 4 day shift, required at least 14 CNAs. -06/19/23 had 8 CNAs for 113 residents on the day shift, required at least 14 CNAs. -06/20/23 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. -06/21/23 had 10 CNAs for 113 residents on the day shift, required at least 14 CNAs. -06/22/23 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. -06/23/23 had 10 CNAs for 113 residents on the day shift, required at least 14 CNAs. -06/24/23 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. 5. For the week of Complaint staffing from 10/29/23 to 11/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/29/23 had 9 CNAs for 137 residents on the day shift, required at least 17 CNAs. -10/30/23 had 8 CNAs for 137 residents on the day shift, required at least 17 CNAs. -10/31/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. -11/01/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. -11/02/23 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. -11/03/23 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs. -11/04/23 had 11 CNAs for 138 residents on the day shift, required at least 17 CNAs. 6. For the 2 weeks of staffing prior to survey from 07/14/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -07/14/24 had 6 CNAs for 144 residents on the	S 560		

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day shift, required at least 18 CNAs.
-07/15/24 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-07/16/24 had 11 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-07/17/24 had 12 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-07/18/24 had 9 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-07/19/24 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs.
-07/20/24 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs.

-07/21/24 had 8 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-07/22/24 had 11 CNAs for 147 residents on the day shift, required at least 18 CNAs.
-07/23/24 had 11 CNAs for 147 residents on the day shift, required at least 18 CNAs.
-07/24/24 had 11 CNAs for 147 residents on the day shift, required at least 18 CNAs.
-07/25/24 had 13 CNAs for 147 residents on the day shift, required at least 18 CNAs.
-07/26/24 had 13 CNAs for 149 residents on the day shift, required at least 19 CNAs.
-07/27/24 had 8 CNAs for 146 residents on the day shift, required at least 18 CNAs.

On 08/01/2024 at 09:08 during an interview with the Staffing Coordinator, the surveyor asked if she was aware of the New Jersey CNA staffing minimums. The Staffing Coordinator confirmed that she is. At that time, the surveyor asked if she feels the facility is meeting those ratios. The Staffing Coordinator replied, "Yes."

On the same date at 12:29 PM during an interview with the Licensed Nursing Home Administrator (LNHA), the surveyor asked if the

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S 560	Continued From page 6 facility is meeting the New Jersey CNA and Direct Care Staffing ratios. The LNHA replied, "Some yes, some no." A review of the facility policy titled, "Staffing, Sufficient and Competent Nursing" with a revised date of August 2022 revealed that, "8. Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing."	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 B. Wing Y2	9/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	1001 CENTER ST 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 F0636	Correction	ID Prefix F0640	Correction	ID Prefix F0656	Correction
Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	08/05/2024	LSC	08/05/2024	LSC	08/05/2024
ID Prefix F0690	Correction	ID Prefix F0695	Correction	ID Prefix F0740	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.40	Completed
LSC	08/05/2024	LSC	08/05/2024	LSC	08/05/2024
ID Prefix F0758	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	08/05/2024	LSC	08/05/2024	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? ☐ YES ☐ NO
8/2/2024	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061522 Y1	A. Building B. Wing Y2	9/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	1001 CENTER ST 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	08/05/2024	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	
8/2/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING **01** B. WING _____	**08/02/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	**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) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 7/30/24 and 7/31/24, Seacrest Rehabilitation and Healthcare was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Seacrest Rehabilitation and Healthcare center is a three-story, Type II unprotected building with a one-story addition of the same construction, (no basement) that was built in January 1985. The facility is divided into 10-smoke zones. The interior diesel generator does approximately 30 % of the building as per the Maintenance Director. The facility is licensed for 171 beds, and is currently occupying 146.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview and	K 345	The fire alarm sensitivity test is	8/30/24

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

Electronically Signed | 08/16/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING 01 B. WING _____	08/02/2024

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K 345	Continued From page 1 documentation review on 07/30/2024, in the presence of th U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that smoke detection sensitivity testing was completed for the facility smoke detectors in accordance with NFPA 72 (2010Edition) Section 14.1.1, 14.4.5.3.2. This deficient practice had the potential to affect all residents and was evidenced by the following: At 9:10AM, the surveyor reviewed all related fire alarm documentation provided by the [redacted] from the fire alarm vendor to determine if the sensitivity test was performed, the surveyor could not find evidence or record that indicate sensitivity test was performed. In an interview at the time, the [redacted] confirmed the above observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2024. N.J.A.C. 8:39-31.1(e) NFPA 70,72.	K 345	scheduled to be conducted on 8/27/24 by Cintas. All residents have the potential to be affected. U.S. FOIA (b) (6) [redacted] was educated on ensuring smoke detection sensitivity testing is completed as per accordance of NFPA 702 (2010 edition) Section 14.1.1, 14.4.5.3.2. The Plant Operation Manager will audit annually ensuring sensitivity testing is completed as per accordance of NFPA 702 (2010 edition) Section 14.1.1, 14.4.5.3.2. The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting for 12 months by the administrator or designee with suggested recommendations made by the committee.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and	K 347	Smoke detection systems were installed	8/14/24

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	315218	A. BUILDING 01 B. WING _____	08/02/2024

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K 347	Continued From page 2 documentation review on 07/30/2024, in the presence of th U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that space open to the corridor had smoke detection systems in accordance with NFPA 101 Life Safety Code ,2021 Edition Section 19.3.6.1.(7)(a).This deficient practice had the potential to affect all residents and was evidenced by the following: During the tour between 9:15AM and 3:30PM the surveyor observed 2 of 2 dining/lounge areas occupied by residents with 4 windows and 2 doors that opened to the corridor. The dining/lounge areas did not have a smoke detection system. In an interview at the time, the U.S. FOIA (b)(6) confirmed the above observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2024. N.J.A.C 8:39-31.1(c),31.2(e) NFPA 70,72.	K 347	on 8/14/24 in the 2 dining areas. All residents have the potential to be affected. U.S. FOIA (b) (6) was educated on ensuring proper smoke detection systems are provided in open corridors in accordance with NFPA 101 Life Safety Code, 2021 Edition Section 19.3.6.1.(7)(a). The Plant Operation Manager will audit quarterly for 12 months all open corridors to have smoke detection systems in accordance with NFPA 101 Life Safety Code, 2021 Edition Section 19.3.6.1.(7)(a). The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting for 12 months by the administrator or designee with suggested recommendations made by the committee.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		8/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING 01 B. WING	08/02/2024

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K 353	Continued From page 3 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/30/2024, in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to maintain the sprinkler system and failed to ensure the ceiling level was smoke resisting in accordance with NFPA 101,2012 Edition, Section 9.7.5,9.7.7,9.7.8, NFPA 25, 2011 Edition, Section 5.2.1.1.1(2).This deficient practice had the potential to affect all residents and was evidenced by the following: 1. At 10:11 AM, the surveyor observed an opening in the ceiling of the clean linen room. 2. At 10:35AM, surveyor and the U.S. FOIA (b) observed approximately 4" by 3" broken ceiling tile in second floor tub room. 3. At 12:30PM, the surveyor observed 18 of 21 sprinkler heads with excessive corrosion buildup in the kitchen. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation.	K 353	The opening in the ceiling of the clean linen room was repaired on 7/31/24 in accordance with NFPA 101,2012 Edition Section 5.2.1.1.1(2). The broken ceiling tile in the second-floor tub room was repaired on 7/31/24 in accordance with NFPA 101,2012 Edition Section 5.2.1.1.1(2). The 18 sprinkler heads with excessive corrosion in the kitchen were inspected by Cintas and have been deemed functional and in working order in accordance with NFPA 101,2012 Edition Section 5.2.1.1.1(2). All residents have the potential to be affected. U.S. FOIA (b) (6) [redacted] was educated on maintaining the sprinkler system and ensuring the ceiling level is smoke resistance in accordance with NFPA 101,2012 Edition Section 5.2.1.1.1(2). The Plant Operation Manager will audit Quartey our sprinkler system and ceilings ensuring it is in accordance with NFPA 101,2012 Edition Section 5.2.1.1.1(2). The contents of the audit above will be reported by the Plant Operations Manager	

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K 353	Continued From page 4 The facility's NJ Exec Order 26.4b1 was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2024. N.J.A.C 8:39-31.2(e) NFPA 25.	K 353	or his designee and reviewed at the quarterly QA meeting for 12 months by the administrator or designee with suggested recommendations made by the committee.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or	K 363		8/7/24

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K 363	Continued From page 5 frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/30/2024, in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101,2012 Edition, Section 19.3.6,19.3.6.3,19.6.3.1and 19.6.5. This deficient practice was evidenced by the following: During the tour from 9:15AM to 3:30PM, the surveyor, U.S. FOIA (b)(6) observed the following: 1.Resident room door #102 will not latch, hardware issue. 2. Resident room door #226 will not latch, hardware issue. 3. Resident room door #305 rub into its frame. 4.Double door next to room #126 had a gap between doors when tested by U.S. FOIA (b) [redacted]. In an interview at the time, the U.S. FOIA (b) (6) confirmed the above observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2024. N.J.A.C 8:39-31.2(e).	K 363	The door latch in Resident room #102 and resident room #226 was repaired in accordance with the requirements of NFPA 101,2012 Edition, Section 19.3.6,19.3.6.1 and 19.6.5. Resident room door #305 was repaired in accordance with the requirements of NFPA 101,2012 Edition, Section 19.3.6,19.3.6.1 and 19.6.5. The gap between the double doors by room #126 was repaired with an astragal molding in accordance with the requirements of NFPA 101,2012 Edition, Section 19.3.6,19.3.6.1 and 19.6.5. All residents have the potential to be affected. US FOIA (b)(6) [redacted] was educated on the requirements of NFPA 101,2012 Edition, Section 19.3.6,19.3.6.1 and 19.6.5. The Plant Operation Manager will audit quarterly for 12 months all doors ensuring they in accordance with requirements of NFPA 101,2012 Edition, Section 19.3.6,19.3.6.1 and 19.6.5. The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting for 12 months by the administrator or designee with suggested	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 363	Continued From page 6 NFPA101,2012 LSC Edition.	K 363	recommendations made by the committee.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/30/2024, in the presence of the [redacted], it was determined that the facility failed to ensure that ventilation systems were being properly maintained in accordance with National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During the tour between 9:15AM and 3:15 PM in the presence of U.S. FOIA (b)(6) the surveyor observed residents' rooms #210, #311, #312 and #313 the exhaust systems in the bathroom was not working when tested by [redacted]. In an interview at the time, the U.S. FOIA (b)(6) confirmed the above observation.	K 521	New exhaust fans were ordered for rooms #210, #311, #312, and #313 and set to be delivered on 8/16/24. The exhaust fans in rooms #210, #311, #312, and #313 were repaired on 8/19/24 ensuring proper ventilation systems in accordance with NFPA 90A. All residents have the potential to be affected. U.S. FOIA (b) (6) was educated proper ventilation systems in accordance with NFPA 90A. The Plant Operation Manager or designee will audit monthly ventilation systems ensuring they are being maintained in accordance of NFPA 90A. The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting for 12 months by the administrator or designee with suggested	8/19/24

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K 521	Continued From page 7 The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2024. NFPA 90A. N.J.A.C 8:39-31.2(e).	K 521	recommendations made by the committee.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 07/30/2024, in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to test and inspect the elevators annually as required by NFPA 101,2012 Edition, Section	K 531	The annual elevator inspection was conducted on 8/1/24 for elevator #1 and elevator #2. All residents have the potential to be affected. U.S. FOIA (b) (6) [redacted] was educated on the annual testing and inspection of the	8/5/24

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SEACREST REHABILITATION AND HEALTHCARE CENTER	**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) COMPLETION DATE
K 531	Continued From page 8 19.5.3.9,9.4.2,9.4.3 with the New Jersey Department of Community Affairs Division of Code and Standards Elevator Safety Division. This deficient practice had the potential to affect all residents and was evidenced by the following: At 10:45AM, a review of the facility's elevator inspection certificate's revealed that 2 of 2 elevator devices #1 and #2 were last inspected 11/2/2022 and were good for use until 10/11/2023. The annual elevator inspection was over 9-months overdue. In an interview, at 12:30PM, the facility's maintenance director stated, "The annual elevator test is scheduled for 08/01/2024." In an interview at the time, the U.S. FOIA (b) (6) confirmed the above observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2024. N.J.A.C 8:39-31(e) NFPA 101,2012 Edition.	K 531	elevators as required by NFPA 101,2012 Edition, Section 19.5.3.9,9.4.2,9.4.3with the New Jersey Department of Community Affairs Division of Code and Standards Elevator Safety Division. The Plant Operation Manager will audit annually ensuring we are in accordance with NFPA 101,2012 Edition, Section 19.5.3.9,9.4.2,9.4.3with the New Jersey Department of Community Affairs Division of Code and Standards Elevator Safety Division. The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting for 12 months by the administrator or designee with suggested recommendations made by the committee.	
K 791 SS=F	Construction, Repair, and Improvement Operati CFR(s): NFPA 101 Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1 This REQUIREMENT is not met as evidenced	K 791		8/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING 01 B. WING _____	08/02/2024

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

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K 791	Continued From page 9 by: Based on surveyor observation and interview on 7/31/24, in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to conduct inspections of exit areas while construction was in progress. This deficient practice could affect all residents residing in the facility and was evidenced by the following: A tour of the building revealed that the adult day services area was under construction, this construction also caused the exit/egress routes by resident rooms 120 and 121 to be compromisd, due to construction debris on the exit/egress routes. TheU.S. FOIA (b) (6) stated in an interview at 12:50 p.m. that the construction/excavation daily inspections were not conducted by the facility to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1 NJAC 8:39-31.2(e)	K 791	The construction site by rooms 120 and 121 was cleared of debris on 7/31 ensuring its ability to be used instantly in case of emergency and compliance with NFPA 241.18.7.9, 19.7.9, 4.6.10, 7.1.10.1. All residents have the potential to be affected. U.S. FOIA (b) (6) was educated on any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241.18.7.9, 19.7.9, 4.6.10, 7.1.10.1 The Plant Operation Manager will audit daily all construction sites ensuring its ability to be used instantly in case of emergency and compliance with NFPA 241.18.7.9, 19.7.9, 4.6.10, 7.1.10.1. The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meetings until the construction job is completed by the administrator or designee with suggested recommendations made by the committee.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and	K 921		8/15/24

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K 921	Continued From page 10 protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, on 07/30/2024, in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to provide the electrical policy for all patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and detailed log of all required tests, test results and repairs in accordance with NFPA 99,2012 Edition, section 10.3,10.5.2.1,10.5.2.1.2,10.5.2.5,10.5.3,10.5.6. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 921	The electrical beds in resident□s rooms #200, #201, #203, #204, #205, #206, #207, #208, #209, #210 and #211 were inspected on 8/8/24 in accordance with NFOA 99,2012 Edition, section 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6. All residents have the potential to be affected. U.S. FOIA (b) (6) [redacted] was educated on proper inspecting of electrical equipment in accordance with NFOA 99,2012 Edition, section 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315218	A. BUILDING **01** B. WING _____	**08/02/2024**

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

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K 921	Continued From page 11 Observation made by the surveyor between 10:53 AM and 12:15PM, on the second floor in resident's rooms #200, #201, #203, #204, #205, #206, #207, #208, #209, #210 and #211 of electrical beds with no inspection stickers. The U.S. FOIA (b) (6) stated that "He was working on the log." The facility did not provide policy and procedures for testing of the equipment, evidence of annual testing and maintenance program for PCREE. In an interview at the time, the U.S. FOIA (b) (6) confirmed the above observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2024. N.J.A.C 8:39-31.2(e) NFPA 99.	K 921	The Plant Operation Manager will audit annually maintenance logs ensuring we are meeting the requirements in accordance with NFOA 99,2012 Edition, section 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6. The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting for 12 months by the administrator or designee with suggested recommendations made by the committee.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.	K 923		8/14/24

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K 923	Continued From page 12 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/30/2024, in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that medical oxygen cylinders were being stored in accordance with NFPA 101,2012 Edition. Section 19.3.2.4,8.7 and NFPA 99. This deficient practice had the potential to affect all residents and was evidenced by the following: At 11:20AM, the surveyor observed 13 empty cylinders of portable oxygen were not segregated from 56 full portable oxygen cylinders in the oxygen storage closet. There were no signs observed indicating if the cylinders were FULL or	K 923	The 13 empty cylinders of portable oxygen were separated from the 56 full portable oxygen cylinders. A sign that says, FULL was placed over the full portable oxygen cylinders and a sign, saying, EMPTY was placed over the empty portable oxygen cylinders. All residents have the potential to be affected U.S. FOIA (b) (6) [redacted] was educated on proper medical oxygen cylinder storage in accordance with NFPA 101,2012 Edition, Section 19.3.2.4, 8.7 and NFPA 99. The Plant Operation Manager will audit quarterly all medical oxygen cylinder	

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	315218	A. BUILDING **01** B. WING _____	**08/02/2024**

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K 923	Continued From page 13 EMPTY to avoid confusion in an emergency. In an interview at the time, the U.S. FOIA (b)(6) confirmed the above observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 07/31/2024. N.J.A.C 8:39-31.2(e). NFPA 99.	K 923	storage areas ensuring they are in accordance with NFPA 101,2012 Edition, Section 19.3.2.4, 8.7 and NFPA 99. The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting for 12 months by the administrator or designee with suggested recommendations made by the committee.	

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 01 - MAIN BUILDING 01 B. Wing Y2	9/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACREST REHABILITATION AND HEALTHCARE CENTER	1001 CENTER ST 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	08/30/2024	LSC K0347	08/14/2024	LSC K0353	08/05/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	08/07/2024	LSC K0521	08/19/2024	LSC K0531	08/05/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0791	08/05/2024	LSC K0921	08/15/2024	LSC K0923	08/14/2024
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	
8/2/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO