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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **BIG OAK REHABILITATION AND HEALTHCARE CENTER** | **849 BIG OAK ROAD PITTSGROVE, NJ 08318** |

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| F 000 | INITIAL COMMENTS<br><br>Complaint NJ#'s: 169064, 169913, 173150, 174063, 174084, 174525, 176956<br><br>Survey Date: 12/4/24 to 12/11/24<br><br>Census: 78<br><br>Sample: 18 + 3 closed records<br><br>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 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, | F 584 | | 12/24/24 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Electronically Signed | | 12/31/2024 |

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 584 | Continued From page 1<br>and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to maintain the resident's furnishings and living area in a clean and home like environment.<br><br>This deficient practice was identified for 1 of 2 residents (Resident #66) on 1 of 2 nursing units [redacted]Unit) reviewed for a clean, comfortable, home like environment and was evidenced by the following:<br><br>1. On 12/4/24 at 10:44 AM, the surveyor entered Resident #66's room and observed that the floor was visibly dirty and was soiled with both dried paint and debris. The resident's over bed table frame was rusty.<br><br>The surveyor reviewed the medical record for | F 584 | F584 – Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)<br><br>Resident #66 was moved to another room, and room was placed out of service for repairs. Flooring was replaced, the overbed table was replaced, the holes in the wall were repaired. All residents have the potential to be affected by the deficient practice. An audit was completed for tray tables throughout the facility and those in poor condition were replaced.<br><br>An audit was completed to review the conditions of resident rooms throughout the facility.<br><br>The Director of Nursing, Administrator | |

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| F 584 | Continued From page 2<br>Resident #66.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted]<br><br>A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS revealed the resident had one NJ Exec Order 26.4b1 that was present upon admission/entry or reentry to the facility and one NJ Exec Order 26.4b1 .<br><br>A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26, that the resident wished to remain in the facility for Long Term Care. Goals included that the resident will state he/she is NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with care and services. Interventions included: ...Follow resident's wishes as he/she expresses them.<br><br>On 12/6/24 at 1:53 PM, the surveyor observed Resident #66 NJ Exec Order 26.4b1 while lying in bed. The surveyor noted that the resident's flooring | F 584 | and Housekeeping Director will conduct weekly rounds of resident rooms x 4 weeks, then once every other week for 2 months. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.<br>.<br>12/24/24 | |

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|---|---|---|---|---|
| F 584 | Continued From page 3 | F 584 | | |

was heavily soiled with a black substance. Next to the resident's bed there was a red and pink substance on the floor. The surveyor noted that the wood around the resident's window frame was peeling and chipped in multiple areas. The resident's television was turned on, but was not in service. The resident stated that the television was not working and he/she had no remote control. The surveyor also noted that the protective cover on top of the resident's over bed table was chipped and had exposed wood around the edges. There were no personal effects or decor noted to personalize the resident's room or offer a home like environment.

On 12/6/24 at 2:14 PM, the surveyor interviewed Housekeeping (HK) #1 who stated that she had already cleaned Resident #66's room and cleaned the counter tops, sills, high and low dusting, and the bathroom. The surveyor asked if the floor was mopped and the HK stated, yes.

On 12/6/24 at 2:19 PM, the surveyor accompanied HK #1 and the U.S. FOIA (b)(6) into the resident's room. When the surveyor questioned the U.S. FOI about the condition of the resident's flooring she stated that in NJ Exec Orde the facility changed the whole floor on the nursing unit, but not Resident #66's room. The U.S. FOIA stated that the red substance on the floor next to the resident's bed was ketchup and should have been cleaned. The U.S. FO stated that the dried pink stuff on the floor was cranberry juice. The U.S. FO stated that HK had to clean it.

At that time, the surveyor showed the NJ Exec the condition of the resident's over bed table. The U.S. FO stated, "We have to report and replace it soon because the resident could be cut." The U.S. FO

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|---|---|---|---|---|
| F 584 | Continued From page 4 | F 584 | | |

further stated that the table had to be replaced because it was a safety issue.

The surveyor asked the U.S. FO if U.S. FO was responsible to clean the dirt and debris off of the outer heater cover, and the U.S. FO stated that the flooring and the heater cover were the responsibility of maintenance. The U.S. FO then proceeded to remove the resident's over bed table from the room and stated that she would get another table now. The U.S. FO stated they had new tables. The U.S. FO stated that the rusted table was not supposed to be in the room. Resident #66 then stated that the table had been like that since he/she arrived at the facility. The U.S. FO proceeded to call the U.S. FOIA (b)(6) ) to the room.

On 12/6/24 at 2:29 PM, the surveyor interviewed the U.S. FOIA about the peeling paint and holes above the resident's television and around the resident's window frame and heater cover, and the condition of the flooring and over bed table. The U.S. FOI stated that he did not know when the resident's room was painted. The U.S. FOI stated that he reported the condition of the resident's flooring to the U.S. FOIA (b)(6) ) many times. The U.S. FOIA stated that no one had reported the holes in the wall. The U.S. FO stated they had to clear the room so that he could paint. The U.S. FOIA further stated that this was the only resident room that was like that.

The U.S. FOI further stated, "That table ought to be in the trash can." The U.S. FOIA stated that he did not know if anyone told him. The U.S. FOI stated that the facility did not provide television remotes, but agreed to give the resident a new one. The resident stated, "Thank you."

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| F 584 | Continued From page 5<br>At that time, the [U.S. FOIA] provided the surveyor with documentation that indicated the resident's room was last carbolized (deep cleaned) on [NJ Exec Order 26.4b].<br><br>On 12/6/24 at 2:38 PM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who stated that she had not noticed the condition of the resident's over bed table previously. The table wobbled as the [U.S. FO] pushed it down the hall.<br><br>On 12/9/24 at 1:43 PM, the [U.S. FOIA (b)(6)], in the presence of the U.S. FOIA (b)(6) ) and the survey team, acknowledged that the resident's overhead table should have been maintained in good condition. The [U.S. FOIA (b)(6)] stated, "we do environmental rounds rounds twice weekly." The [U.S. FOIA (b)(6)] stated it was an older building, but it should still be clean. The [U.S. FOIA (b)(6)] stated we changed chemical companies and thought it would be better to a certain degree. The [U.S. FOIA (b)(6)] stated that he rounded with the U.S. FOIA (b)(6) and had a plan in place to go through each room, but things got pushed off due to emergencies, and planned to get back to it.<br><br>On 12/11/24 at 10:50 AM, The [U.S. FOIA (b)(6)] stated that they took the resident's room out of service and closed it down until repairs were made. The [U.S. FOIA (b)(6)] stated that, "the resident will return to the room when it is in better condition." The [U.S. FOIA (b)(6)] further stated that the the resident was very happy. The [U.S. FOIA (b)(6)] stated the resident wanted to hang up pictures in the room. The surveyor asked why the facility had not hung any pictures up in the room prior to surveyor inquiry, and the [U.S. FOIA (b)(6)] who was present stated that the resident was [NJ Exec Order 26.4b1], and the [NJ Exec Order 26.4b1] The | F 584 | | |

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|---|---|---|---|---|
| F 584 | Continued From page 6 | F 584 | | |

U.S. FOIA stated that she did not know if the resident was offered assistance prior to hang his/her pictures to ensure a home like environment.

On 12/11/24 at 11:00 AM, The U.S. FOIA (b)(6) stated that they did an audit the day prior and there were eight over bed tables that were removed from resident rooms. The surveyor asked if the over bed tables had rusted frames and chipped protective coating on the surface, and the U.S. FOIA (b)(6) stated that, "the over bed tables were not cosmetically desirable or aesthetically pleasing."

The Licensed Practical Nurse/Unit Manager #2/Infection Preventionist (LPN/UM #2/IP), who was present at that time, stated that it was an increased risk for infection to have the protective cover chipped away from the top of the over bed table because particles could get stuck in the exposed particle board and could not be properly cleaned and sanitized.

A review of the facility's policy, "Homelike Environment" updated April 2024, included, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.
Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: clean, sanitary and orderly environment; ...inviting colors and decor; personalized furniture and room arrangements; clean bed and bath linens that are in good

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| F 584 | Continued From page 7<br>condition;...<br><br>A review of the facility's policy, "Cleaning and Disinfecting Residents' Rooms" reviewed April 2024, included, Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visible soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled.<br>...Terminal Room Cleaning (fully cleaned and disinfectant surfaces in a patient room): Terminal room cleaning is done when the resident is transferred, discharged or expires... | F 584 | | |
| F 600 SS=D | NJAC 8:39-31.4 (a), (f)<br>Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by: | F 600 | | 12/17/24 |

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| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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| F 600 | Continued From page 8<br>Based on interview, record review, and review of facility documents, it was determined that the facilty failed to ensure that an NJ Exec Order 26.4b1 of NJ Exec Order 2 was immediately reported to a supervisor in accordance with the facility NJ Exec Order policy to ensure the safety of all residents at the facility .<br><br>This deficient practice was identified for 1 of 1 resident (Resident #33) reviewed for NJ Exec Order 2 and was evidenced by the following:<br><br>On 12/6/24 at 9:04 AM, the surveyor completed a tour of the NJ Exec Ord Unit with Certified Nursing Assistant (CNA) #3. When interviewed, CNA #3 stated that on NJ Exec Order 26.4b1, Resident #65 reported that an U.S. FOIA (b NJ Exec Order 2 his/her roommate's NJ Exec Order 26. (Resident #33) . The surveyor asked CNA #3 when she was supposed to report an NJ Exec Order 26.4b1 of NJ Exec Order 26. CNA #3 stated that she was supposed to report any NJ Exec Order 26.4b1 of NJ Exec Order 2 to her supervisor right away. CNA #3 further stated that she did not report the NJ Exec Order 26.4b1 of NJ Exec Order 2 to the administration yet because Resident #65 stated that he/she wanted to speak with the state surveyor first.<br><br>A review of Resident #65's most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS revealed that the resident had NJ Ex<br><br>On 12/6/24 at 9:41 AM, the surveyor interviewed Resident #65 who stated that no one NJ Exec Order 26 Resident #33's NJ Exec Order 26. Resident #65 then stated | F 600 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed.<br>F600 Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>Resident #65<br><br>Resident #33<br><br>The US FOIA (b identified in the NJ Exec Order 26.4b1 of NJ Exec Order and the US FOIA (b who failed to report where NJ Exec Order 26.4b1 immediately pending investigation. The US FOIA (b who failed to report received individual in servicing and abuse training. A facility wide in-service was initiated on abuse, neglect, identifying and reporting. All residents have to potential to be affected by the deficient practice Facility wide ongoing in servicing and education on abuse, neglect, mistreatment, identifying and reporting of abuse. The Director of Nursing, Unit Managers, and Social Worker will conduct resident interviews with 6 residents related to concerns of reported abuse weekly for 4 weeks, then every other week for 2 months. The results of the | |

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| F 600 | Continued From page 9<br>that Resident #33 NJ Exec Order 26 the staff's NJ Exec Order 26.4<br><br>At that time, the surveyor observed Resident #33 lying in bed with their NJ Exec Order 26.4b1 and was NJ Exec Order 2 to be NJ Exec Order 26.4b1 at that time.<br><br>A review of Resident #33's Admission Record, an admission summary, revealed the resident had diagnoses which included, NJ Exec Order 26.4b1 [redacted]<br><br>A review of Resident #33's quarterly MDS, dated NJ Exec Order 26.4b1 included the resident had a BIMS score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1 .<br><br>On 12/6/24 at 1:39 PM, the surveyor interviewed the U.S. FOIA (b)(6) ) in the presence of the U.S. FOIA (b)(6) ated that any NJ Exec Order 26.4b1 should be reported to a supervisor right away. The U.S. FOIA (b)(6) further stated that they were not aware of any NJ Exec Order 26.4b1 and would begin the investigation right away.<br><br>On 12/9/24 at 2:49 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that CNA #3 should have told Resident #65 that it was her obligation to report the NJ Exec Order 26.4b1 immediately.<br><br>On 12/11/24 at 11:05 AM, the U.S. FOIA (b)(6) in the presence of the NJ Exec Orde and the survey team, stated that CNA #3 received NJ Exec Order 26.4b1 and that their "process should be revisited." | F 600 | audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.<br>. | |

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| F 600 | Continued From page 10<br><br>A review of the facility's "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" policy updated April 2024, included:<br>If a resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported | F 600 | | |
| F 623 SS=D | NJAC 8:39-4.1(a) 5<br>Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section. | F 623 | | 12/12/24 |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| F 623 | Continued From page 11<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; | F 623 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 623 | Continued From page 12 | F 623 | | |

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 623 | Continued From page 13<br>Based on interview, record review, and review of facility documents, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of a resident hospitalization.<br><br>This deficient practice was identified for 1 of 1 resident (Resident #20) reviewed for NJ Exec Order 26.4b1 and was evidenced by the following:<br><br>On 12/4/24 at 10:22 AM, during the initial tour the surveyor observed Resident #20 lying in bed with their eyes closed.<br><br>On 12/6/24 at 10:00 AM, the surveyor reviewed the medical record for Resident #20.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: NJ Exec Order 26.4b1 [redacted]<br><br>A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS revealed the resident had an admission reentry from the NJ Exec Order 26.4b1.<br><br>A review of the Progress Notes (PN) dated NJ Exec Order 26.4b1 at 11:34 PM, reflected the resident was admitted NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 [redacted]. | F 623 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br>F623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)<br><br>Resident #20<br>Ombudsman was notified of resident transfer.<br><br>The Social Worker submitted the monthly transfer/discharge report for NJ Exec Order 26.4b1 [redacted]<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.<br>Residents who have transferred or discharged have the potential to be affected.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>Social Worker was educated by the LNHA on the importance of reporting transfer/discharges to Ombudsman office<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br><br>The LNHA will be added to the Ombudsman communication notifications.<br>The LNHA will conduct an audit twice monthly for 1 month then monthly for 3 | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 623 | Continued From page 14<br>On 12/6/24 10:09 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the notification to the State Long-Term Care U.S. FOIA (b)(6) ) was not completed. At that time, the surveyor requested a policy related to notification to the U.S. FOIA (b)(6) office for transfers and discharges.<br><br>On 12/9/24 at 11:44 AM, the surveyor interviewed the U.S. FOIA (b)(6) ) who stated that the U.S. FOIA (b)(6) ) was responsible for notifying the U.S. FOIA (b)(6) office which was submitted monthly. The U.S. FOIA (b)(6) stated that he thought they were being sent monthly, but never obtained a copy to confirm it was being done. The U.S. FOIA (b)(6) stated that it was important to send a notification the U.S. FOIA (b)(6) office because they were in partnership for care of the residents.<br><br>On 12/9/24 at 11:55 AM, the surveyor interviewed the U.S. FOIA (b) who stated that he started at the facility in NJ Exec Order 26.4b1. He further stated that he was responsible for notifying the U.S. FOIA (b)(6) office of the discharges and transfers and that he sent them monthly via email. The U.S. FOIA (b) confirmed Resident #20 was missed in NJ Exec Order 26.4b1, because he was still looking for the form and "cleaning up the mess" from the previous U.S. FOIA (b)(6). He stated that he did not start notifying the U.S. FOIA (b)(6) office until NJ Exec Order 26.4b1 and did not go back and complete those prior to NJ Exec Order 26.4b1 The U.S. FOIA (b)(6) stated that it was important to notify the U.S. FOIA (b)(6) office, so they know when the resident was transferred out to the hospital or discharged home.<br><br>On 12/11/24 at 11:04 AM, the U.S. FOIA (b)(6) acknowledged in the presence of the U.S. FOIA (b)(6) | F 623 | months. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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|---|---|
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| F 623 | Continued From page 15<br>U.S. FOIA (b)(6) the survey team, that the notification to the U.S. FOIA (b)(6) office should have been sent prior to surveyor inquiry.<br><br>A review of the facility's "Transfer or Discharge, Facility Initiated" policy, dated October 2022, included, "Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that include all notice content requirements)." | F 623 | | |
| F 656 SS=E | NJAC 8:39-4.1(a)3<br>Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse | F 656 | | 12/16/24 |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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| F 656 | Continued From page 16<br>treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to develop an individual comprehensive care plan (ICCP) to include a.) a resident's use of NJ Exec Order 26.4b1 [redacted] and, b.) a resident's NJ Exec Order 26.4 services.<br><br>This deficient practice was identified for 1 of 5 residents (Resident #70) reviewed for medication regimen and 1 of 2 residents (Resident #37) reviewed for NJ Exec Order 26.4 and was evidenced by the | F 656 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br>F656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>Resident #37 Care plan was reviewed and updated to include a NJ Exec Order 26.4 care plan<br><br>Resident #70 Care plan was reviewed and updated to included an NJ Exec Order 26.4b1 | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| F 656 | Continued From page 17<br>following:<br><br>1.) On 12/5/24 at 12:21 PM, the surveyor observed Resident #70 eating lunch in his/her room.<br><br>On 12/6/24 at 11:29 AM, the surveyor reviewed the medical record for Resident #70.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [redacted]<br><br>A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's [redacted]. Further review of the MDS included the resident was taking an [redacted] medication.<br><br>A review of the Order Summary Report, dated as of [redacted], included the following Physician Orders (PO):<br>A PO, dated [redacted].<br>A PO, dated [redacted], for [redacted] medication monitoring - monitor for [redacted] | F 656 | [redacted] care plan<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.<br>All residents have the potential to be affected by the deficient practice<br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>An audit was conducted to ensure all residents with anticoagulant therapy and/or hospice services had the required care plan.<br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br>The Director of Nursing and Unit managers will review new admissions on the next business day to ensure if required anticoagulant therapy or hospice services are added to the comprehensive care plan. The Director of Nursing or Unit Manager will run a order report for any new anticoagulation medication or hospice service to ensure it is updated on the care plan twice weekly for 3 months.<br>The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 656 | Continued From page 18<br><br>A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) included the above PO for NJ Exec Order 26.4b1 monitoring.<br><br>A review of the resident's individual comprehensive care plan (ICCP) did not include the resident's diagnosis of NJ Exec Order 26.4b1<br><br>On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated nurses should monitor residents who were on NJ Exec Order 26.4b1 medications for NJ Exec Order 26.4b1. The U.S. FOIA further stated the U.S. FOIA (b)(6) were responsible for developing the resident's ICCP so that "the staff know how to properly care for the resident safely."<br><br>On 12/9/24 at 12:11 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated nurses should monitor residents who were on NJ Exec Order 26.4b1 medications for NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) further stated that any nurse could develop the resident's ICCP because "it is the map to the resident's care and tells staff what they need to know about the resident."<br><br>On 12/9/24 at 1:19 PM, in the presence of the U.S. FOIA (b)(6), and the survey team, the surveyor interviewed the U.S. FOIA (b)(6) who stated the unit managers and the U.S. FOIA (b) were responsible for developing the resident's ICCP so that "the proper plan of care is executed for the resident." At that time, the surveyor informed the U.S. FOIA (b) of Resident #70's | F 656 | | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 656 | Continued From page 19 | F 656 | | |

ICCP and the [redacted] confirmed the ICCP should have included the resident's diagnosis of [redacted] and the use of [redacted] medications.

2.) On 12/4/24 at 10:01 AM, during the initial tour, the surveyor observed Resident #37 lying in bed awake. The surveyor interviewed the resident who stated they were [redacted].

On 12/9/24 at 10:45 AM, the surveyor reviewed the medical record for Resident #37.

A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: [redacted]

A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated a [redacted]. Further review of the MDS revealed the resident was [redacted].

A review of the ICCP included a focus area, dated [redacted], that the resident had an advanced directive/wishes in place. Interventions included: [redacted]) and do no [redacted] Further review of the ICCP did not include a [redacted] focus area or interventions.

On 12/9/24 at 12:17 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated the care plan was in the resident's medical records. LPN #1 stated that the [redacted] was responsible for developing the care

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 656 | Continued From page 20 | F 656 | | |

plan. She stated that a care plan ensured the resident received the proper care from everyone.

On 12/9/24 at 12:24 PM, the surveyor interviewed LPN #2 who stated the nurses were responsible for creating the care plans. She stated that a care plan was how staff knew how to care for the resident. She further stated that if a resident was on [redacted] there should be a care plan related to [redacted] because "we still have to care for the resident."

On 12/9/24 at 12:33 PM, the surveyor interviewed the LPN/UM #1 for the [redacted] Wing who stated the UMs updated the care plan, but any nurse could create one. She stated that the care plan was the guideline for resident specific plan of care. She further stated that the importance of the care plan was to ensure residents were receiving the specific and appropriate plan of care. LPN/UM #1 stated that if a resident was on [redacted] there should be a care plan. At that time, LPN/UM #1 confirmed Resident #37 was on [redacted]

On 12/9/24 at 12:39 PM, the surveyor and LPN/UM #1 reviewed the ICCP in the electronic medical record (EMR). LPN/UM #1 confirmed the resident did not have a focus area or interventions related to [redacted]. She stated that the care plan should have been developed within 72 hours of the resident being admitted on [redacted] At that time, LPN/UM #1 stated she was going to develop the [redacted] care plan.

On 12/11/24 at 11:15 AM, the [redacted] stated, in the presence of the [redacted] and the survey team, that the [redacted] care plan should have been

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 21<br>developed prior to surveyor inquiry.<br><br>A review of the facility's "Care Plans, Comprehensive Person-Centered" policy, updated April 2024, included, "The interdisciplinary team (IDT) ... develops and implements a comprehensive, person-centered care plan for each resident," and, "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." Further review of the policy included, "The comprehensive, person-centered care plan: ... describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ..." and, "reflects currently recognized standards of practice for problem areas and conditions."<br><br>A review of the facility's "Hospice Program" policy, updated April 2024, included, "13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by the facility." | F 656 | | |
| F 658 SS=D | NJAC 8:39-11.2 (e), 27.1 (a)<br>Services Provided Meet Professional Standards<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- | F 658 | | 12/12/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| F 658 | Continued From page 22<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to maintain a professional standard of practice by ensuring a physician's order was in place for monitoring a resident's NJ Exec Order 26.4b1.<br><br>This deficient practice was identified during medication administration record review for 1 of 3 residents (Resident #25) on NJ Exec Order 26 and was evidenced by the following:<br><br>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."<br><br>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a | F 658 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br>F658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>Resident #25 Physician reviewed and added three times a week NJ Exec Order 26.4b1 [redacted]<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.<br>Residents who are diabetic have the potential to be affected by the deficient practice.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>The Director of Nursing provided education to nursing staff on diabetic residents and ensure blood glucose checks are scheduled.<br>An audit was conducted of diabetic residents to ensure blood glucose checks were scheduled as physician orders.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br>The Director of Nursing or Unit Manager will audit diabetic residents to ensure | |

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|---|---|---|---|---|
| F 658 | Continued From page 23<br>registered nurse or licensed or otherwise legally authorized physician or dentist."<br><br>On 12/4/24 at 10:12 AM, the surveyor observed that Resident #25 was not in their room.<br><br>A review of the Admission Record, an admission summary, revealed that Resident #25 was readmitted from an NJ Exec Order 26.4b1 hospital and had diagnoses that included, but were not limited to: NJ Exec Order 26.4b1<br><br>A review of the comprehensive Minimum Data Set (MDS), an assessment tool, NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1<br><br>A review of the individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order, that the resident was at risk for NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1. The interventions included: Obtain NJ Exec Order 26.4b1 as indicated.<br><br>A review of the physician's Progress Notes (PN) dated NJ Exec Order 26.4b1 indicated to NJ Exec Order 26.4b1<br><br>A review of the Order Summary Report (OSR), active orders as of NJ Exec Order 26.4b1, revealed no physician orders to monitor the resident's NJ Exec Orde<br><br>On 12/05/24 at 3:05 PM, the surveyor interviewed the U.S. FOIA (b)(6), who stated that he saw Resident #25 yesterday ( NJ Exec Order 26.4b1 He further | F 658 | blood glucose checks are scheduled according to physician orders once weekly for 4 weeks, then every other week for 2 months.<br>The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| F 658 | Continued From page 24<br>stated that the resident was on [redacted] and he noticed that the resident did not have an order to monitor the [redacted] levels. The [redacted] stated, he was "going to order" to montior the [redacted] and was unsure why it was not already ordered. He stated "I am not going to lie, it probably was an oversight." The [redacted] stated that the resident should have their [redacted] levels checks at least three (3) times per week. He emphasized "I'll make sure, I put it in."<br><br>On 12/11/2024 at 10:30 AM, the [redacted] stated in the presence of the [redacted], that if there was a discrepancy with monitoring the [redacted] levels after the resident returned from the hospital, her expectation would be for the nurse to ask the physician if they wanted to reorder to monitor the [redacted] levels.<br><br>A review of the undated facility's "Reconciliation of Medications on Admission" policy did not include blood glucose monitoring. | F 658 | | |
| F 686 SS=D | NJAC 8:39- 27.1(a)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and | F 686 | | 12/18/24 |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 686 | Continued From page 25<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to provide a wound treatment in accordance with the physician's orders, the facility policy, and professional standards of nursing practice.<br><br>This deficient practice was identified for 1 of 3 residents (Resident #66) reviewed for NJ Exec Order 26.4b1 and was evidenced by the following:<br><br>On 12/5/24 at 12:23 PM, the surveyor observed Resident #66 lying awake in bed on a NJ Exec Order 26.4 and the sheets were NJ Exec Order 26.4b1 the resident and left parts of the mattress uncovered. The resident had a NJ Exec Order 26.4b1 that covered the resident's NJ Exec Order 26.4b1 that was dated NJ Exec Order 26. When interviewed, the resident stated that they also had a NJ Exec Order 26.4b1 Certified Nursing Assistant (CNA) #1 was present and had begun to set the resident up to eat lunch. When interviewed, CNA #1 stated that she was only assigned to the resident today and floated throughout the facility.<br><br>On 12/5/24 at 10:02 AM, the surveyor reviewed the medical record for Resident #66.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to: NJ Exec Order 26 | F 686 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br>F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>Resident #66<br>The NJ Exec Order 26.4b1 was changed as per physician order.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.<br>Any residents with a wound have the potential to be affected by the deficient practice.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>On 12/5/24 The Director of Nursing and Unit Managers provided education to nursing staff on proper wound care and documentation.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 686 | Continued From page 26<br>NJ Exec Order 26.4b1 [redacted]<br><br>A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS revealed the resident had one NJ Exec Order 26.4b1 that was present upon admission/entry or reentry to the facility and one NJ Exec Order 26.4b1 .<br><br>A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 2 that the resident was at risk for potentiaNJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 , limited mobility, and was updated on NJ Exec Order 26.4b1 to include aNJ Exec Order 26.4b1 [redacted].<br>Interventions included: Follow facility policies and protocols for the prevention/treatment of NJ Exec Or NJ Exec Order 26.4b1<br><br>Further review of the resident's ICCP included a focus area, dated NJ Exec Order 26.4, that the resident was onNJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1 of a NJ Exec Order 26.4b1 of the NJ Exec Order 26.4 Interventions included: NJ Exec Order 26.4b1 as ordered, and monitor for signs and symptoms | F 686 | The Unit Manager(s) will perform rounds on wound dressings twice weekly for 4 weeks, then once weekly for 2 months. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting.<br>The Quality Assurance Performance Improvement committee<br>will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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|---|---|---|---|---|
| F 686 | Continued From page 27<br>of infection (i.e. NJ Exec Order 26.4b1 [redacted]. | F 686 | | |

A review of the Order Summary Report (OSR), dated as of [redacted], included the following physian orders (PO):

1. A PO, dated [redacted], for NJ Exec Order 26.4b1 [redacted] Apply to NJ Exec Order 26.4b1 every day shift every NJ Exec Order 26.4b1 for [redacted] care apply NJ Exec Order 26.4b1 [redacted]) NJ Exec Order 26.4b1 [redacted]

2. A PO, dated [redacted], for NJ Exec Order 26.4b1 [redacted] topically every [redacted] as needed for [redacted] care. Apply NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted]

3. A PO, dated [redacted] for [redacted] Apply to NJ Exec Order 26.4b1 every day shift for [redacted] care. Cleanse with [redacted]), pat dry, apply [redacted]

4. A PO, dated [redacted], for [redacted] Apply to [redacted]

A review of the Progress Notes (PN) included a NJ Exec Order 26.4b1 [redacted] dated NJ Exec Order 26.4b1 [redacted], which included the resident was seen by the NJ Exec Order 26.4b1. Area to [redacted] continued to improve. NJ Exec Order 26.4b1 [redacted] provided. Continue treatments as directed. Further review of PN indicated that there was no nursing note that referenced the resident's NJ Exec Order 26.4b1

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 686 | Continued From page 28 | F 686 | | |

NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 .

On 12/5/24 at 1:01 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that she had worked on both NJ Exec Order 26.4b1. She further stated she left before the end of her shift at NJ Exec Order 26.4b1, and did not get around to doing the resident's NJ Exec Order 26.4b1 treatment. At that time, the surveyor noted that the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 and the resident's NJ Exec O was in NJ Exec Order 26.4b1 with the resident's NJ Exec Order 26.4b1 which was not covered by the bed sheet. The surveyor noted a NJ Exec Order 26.4b1 at the base of the NJ Exec Order 26.4b1 When interviewed, LPN #1 stated that there was a NJ Exec Order 26.4b1 if the resident's NJ Exec was not changed when it was ordered.

At that time, the surveyor reviewed the Treatment Administration Record (TAR) with LPN #1 which revealed a PO for NJ Exec Order 26.4b1 Apply to NJ Exec Order 26.4b1 every day shift every Mon, Wed, Fri for NJ Exec Order 2 care, apply NJ Exec Order 26.4b1 that was signed out as administered on NJ Exec Order 26.4b1 and was also signed out as administered on NJ Exec Order 26.4b1 by LPN #1, though the NJ Exec Order 26.4b was observed as dated NJ Exec Order 26. The surveyor asked LPN #1 why she signed out the treatment as administered if she had not changed the dressing on NJ Exec Order 26., and LPN #1 stated that she may have signed the order out early and had forgotten to do the treatment. LPN #1 further stated that she had also forgotten to report off to the oncoming nurse who covered her shift that she had not completed the resident's NJ Exec Order 26.4b1 before she left the facility for the day.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 686 | Continued From page 29 | F 686 | | |

On 12/5/24 at 1:11 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager #2/Infection Preventionist (LPN/UM #2/IP) who stated that she believed that the resident's [NJ Exec Order 26.4b1] was ordered every other day. The LPN/UM #2/IP stated that the [NJ Exec Order 26.4b1] was not treated effectively if it were not covered. She stated that it was improper documentation and a failure to do the treatment if the [NJ Exec Order 26.4b1] was dated [NJ Exec Order 26.4b1] and was documented as administered on both NJ Exec Order 26.4b1

On 12/5/24 at 2:03 PM, the surveyor interviewed the U.S. FOIA (b)(6) ) who stated that a wound treatment should be rendered per the doctor's order and documented. The [U.S. FOIA (b)(6)] stated that if the resident's [NJ Exec Order 26.4b1] was dated [NJ Exec Order 26.4b1] the treatment was not done and two treatments were missed. The [U.S. FOIA (b)(6)] stated, "That runs the risk of [NJ Exec Order 26.4b1] The [U.S. FOIA (b)(6)] stated that it could also cause the [NJ Exec Order 26.4b1] to worsen if the [NJ Exec Order 26.4b1] was not covered.

On 12/6/24 at 2:05 PM, the surveyor interviewed LPN #1 and asked if she had completed the resident's NJ Exec Order 26.4b1 before she left her shift early on [NJ Exec Order 26.4b1] as she had documented on the resident's TAR, and LPN #1 stated "no, unfortunately." LPN #1 stated that when she changed the NJ Exec Order 26.4b1 the day prior, on [NJ Exec Order 26.4b1] she could not tell who changed it last because it had a lot of NJ Exec Order 26.4b1 on it and it was [NJ Exec Order 26.4b1]"

On 12/9/24 at 2:11 PM, the [U.S. FOIA (b)(6)] in the presence of the U.S. FOIA (b)(6) ) and the survey team, acknowledged that it was her expectation that the resident's [NJ Exec Order 26.4b1] were rendered as ordered and

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 686 | Continued From page 30<br>documented accordingly.<br><br>A review of the facility's undated "Wound Care" policy, included: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.<br>...The following information should be recorded in the resident's medical record:<br>The date and time the wound care was given.<br>The type of wound care given.<br>The name and title of the individual performing the wound care.<br>Any changes in the resident's condition.<br>Any problems or complaints made by the resident related to the procedure.<br>If the resident refused the treatment, the reason for the refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal.<br>The signature and title of the person recording the data.<br>...Notify the supervisor if the resident refuses the wound care.<br>Report other information in accordance with the facility policy and professional standards of practice. | F 686 | | |
| F 698 SS=D | NJAC 8:39-27.1(e), 27.1(a)<br>Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the | F 698 | | 12/12/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 698 | Continued From page 31<br>comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) adjust medication administration times to accommodate for scheduled [NJ Exec Order 26] times and b.) notify the physician that the resident missed medications during dialysis times.<br><br>This deficient practice was identified for 1 of 3 residents (Resident #25) reviewed for [NJ Exec Order 26.4] and was evidenced by the following:<br><br>On 12/4/24 at 10:12 AM, the surveyor observed that Resident #25 was not in their room.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses that included, but were not limited to: [NJ Exec Order 26.4b1] [redacted].<br><br>A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated [NJ Exec Order], included the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Exec Order 26.4b1], which indicated the resident's NJ Exec Order 26.4b1<br>Further review of the MDS revealed the resident received [NJ Exec Order 26] while a resident at the facility.<br><br>A review of the individual comprehensive care plan (ICCP) included a focus area, dated [NJ Exec Order 2], that the resident needed [NJ Exec Order 26] related to [NJ Exec Ord] [redacted] and that the resident went to [NJ Exec Order 26.4] on | F 698 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br>F698 Dialysis CFR(s): 483.25(l)<br><br>Resident #25 Medications for this resident were adjusted to accommodate [NJ Exec Order 26.4] times upon identification, the physician was notified of missed medication doses.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.<br>Residents who attend dialysis have the potential to be affected by the deficient practice.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>The Director of Nursing and Unit Managers provided education to nursing staff on time plotting of medications to reflect dialysis time. The Director of Nursing and Unit managers will complete a chart audit on new admissions to identify residents on dialysis and confirm timing of orders.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br>The Director of Nursing or Unit Manager | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 698 | Continued From page 32<br>NJ Exec Order 26.4b1 with a NJ Exec Ord The ICCP did not include any interventions to schedule medications around the resident's scheduled NJ Exec Order 26 times.<br><br>A review of the Order Summary Report (OSR), dated as of NJ Exec Order 26, included the following physician orders (PO):<br>A PO, dated NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 with a chair time of 5:30 AM.<br>A PO, dated NJ Exec Order 26.4b1 which was scheduled to be administered at 9:30 AM and 9:30 PM.<br>A PO, dated NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 for NJ Exec Order 26.4b, scheduled to be administered at NJ Exec O<br><br>A review of the NJ Exec Order 26.4b1 Medication Administration Record MAR revealed that Resident #25 missed NJ Exec Order 26.4b1 at NJ Exec Order 26.4b1 on their scheduled NJ Exec Order 26 days as follows: NJ Exec Order 26.4b1 .<br>Further review of the MAR revealed that Resident #25 missed NJ Exec Order 26.4b1 , on their scheduled NJ Exec Order 26.4 days as follows: NJ Exec Order .<br>There was no documented evidence that the physician was not notified of the missed doses in NJ Exec Order 26.4b1<br><br>A review of the NJ Exec Order 26.4b1 MAR revealed that Resident #25 missed a total NJ Exec Order 26.4b1 on their scheduled dialysis days as follows: NJ Exec Order 26.4b1 Further | F 698 | will audit dialysis resident orders weekly for 4 weeks, then monthly for 2 months. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 698 | Continued From page 33<br>review of the MAR revealed that Resident #25 missed a total of NJ Exec Order 26.4b1 AM on their scheduled NJ Exec Order 26 days as follows: NJ Exec Order 26.4b1 . There was no documented evidence that the physician was not notified of the missed doses in NJ Exec Order 26.4b1<br><br>A review of the NJ Exec Order 26.4b1 MAR revealed that Resident #25 missed a total of NJ Exec Order 26.4b1 on their scheduled NJ Exec Order 26 days as follows: NJ Exec Order 26.4b1 Further review of the MAR revealed the resident missed NJ Exec Order 26.4b1 the following NJ Exec Order 26 days: NJ Exec Order 26.4b1 There was no documented evidence that the physician was not notified of the missed doses in NJ Exec Order 26.4b1<br><br>On 12/5/24 at 2:38 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM#2), who stated Resident #25's medications should be adjusted around their NJ Exec Order 26.4 schedule. She further stated that if a resident was out of the facility and the medication was not given, the physician should be notified of the missed doses.<br><br>On 12/6/24 at 11:28 AM, the surveyor interviewed the NJ Exec Order 26.4b1 who stated that the medication times should accommodate the NJ Exec Order 26 times. She further stated that the physician should be notified if the medication times did not accommodate the resident's NJ Exec Order 26.4 times and of any missed doses.<br><br>A review of the facility's "Dialysis" policy, updated April 2024, did not include accommodating the resident's medication administration times. | F 698 | | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 698 | Continued From page 34<br>A review of the facility's "Medication Administration" policy, updated April 2024 did not include missed doses. | F 698 | | |
| F 761 SS=D | NJAC 8:39-27.1 (a)<br>Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of pertinent facility documents, it was determined | F 761 | Address how corrective action will be accomplished for those residents found to | 12/12/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 761 | Continued From page 35<br>that the facility failed to store medications properly.<br><br>This deficient practice was observed in 1 of 4 medication carts reviewed for medication storage and labeling and was evidenced by the following:<br><br>On 12/5/24 at 2:14 PM, the surveyor observed the [redacted] Wing high treatment cart in the hallway next to the conference room. A tube of [redacted] were left on the treatment cart, unattended by a [redacted]. The surveyor knocked on the Nursing Office door to notify a [redacted] Licensed Practical Nurse/Unit Manager (LPN/UM) #1 confirmed that the medication was on the cart and immediately removed the medication.<br><br>At that time, LPN/UM #1 stated that the medication should be stored in a plastic bag and secured in the treatment cart.<br><br>On 12/6/24 at 11:41 AM, the surveyor interviewed the [redacted]) who stated that the medications should be stored inside the locked cart.<br><br>A review of the facility's "Storage of Medications" policy, updated April 2024, included, "1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications."<br><br>NJAC 8:39-29.4(h) | F 761 | have been affected by the deficient practice.<br>F761 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)<br><br>Upon identifying the deficient practice the nurse was provided individual education on medication storage.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.<br>All residents have the potential to be affected by the deficient practice.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>The Director of Nursing and Unit Managers provided in servicing to nursing staff on medication storage.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br>The Director of Nursing and Unit Managers will complete audits of medication and treatment carts 5 times weekly for 4 weeks, then twice weekly for 2 months. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee<br>will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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|---|---|
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|---|---|---|---|---|
| F 761 | Continued From page 36 | F 761 | Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |
| F 810 SS=D | Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g)<br><br>§483.60(g) Assistive devices<br>The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to ensure adaptive dining equipment was provided to a resident during meal service as ordered by the physician and indicated on the resident's individual comprehensive care plan (ICCP).<br><br>This deficient practice was identified for 1 of 1 resident (Resident #35) reviewed for [redacted] equipment and was evidenced by the following:<br><br>On 12/4/24 at 12:32 PM, during a lunch meal observation, the surveyor observed Resident #35's clothes contained droppings of pudding. The [redacted] on the resident's lunch tray indicated that the resident should have [redacted] The resident's lunch tray had a built-up fork, a standard spoon and knife, and the cranberry juice and milk were in their original containers with [redacted]<br><br>On 12/5/24 at 12:07 PM, during a lunch meal | F 810 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br>F810 Assistive Devices □ Eating Equipment/Utensils CFR(s): 483.60(g)<br><br>Resident # 35<br>Resident was provided the appropriate [redacted]<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.<br>Residents requiring Assistive Devices/Eating Equipment have the potential to be affected by the deficient practice.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>On 12/5/24 The Director of Nursing/Unit | 12/12/24 |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 810 | Continued From page 37<br>observation, the surveyor observed the resident had a NJ Exec Order 26.4b1 [redacted] The NJ Exec Order 26.4b1.<br><br>The surveyor reviewed the medical record for Resident #35.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1 [redacted]<br><br>A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated a NJ Exec Order 26.4b1 [redacted]. Further review of the MDS revealed the resident depended on staff for the set-up or clean-up for eating.<br><br>A review of the individual comprehensive care plan (ICCP), initiated NJ Exec Order [redacted], included a focus that the resident was at risk for NJ Exec Order 26.4b1 NJ Exec Order 26 due to NJ Exec Order 26.4b1 [redacted]), NJ Exec Order 26.4b1 [redacted], history of NJ Exec Order 26.4b1. Interventions included: NJ Exec Order 26.4b1 [redacted]<br><br>A review of the Order Summary Report (OSR) of active orders as of NJ Exec Order 26.4 included the follwing physician orders (PO): | F 810 | Managers provided facility in servicing on reviewing resident meal tickets and providing appropriate Assistive devices.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br><br>The dietician will conduct weekly audits for 1 month and biweekly for 2 months The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 810 | | F 810 | | |

Continued From page 38

A PO, dated NJ Exec Order 26.4b1, of NJ Exec Order 26.4b1 : NJ Exec Order 26.4b1 .

On 12/4/24 at 1:01 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #5, who stated that the U.S. FOIA (b)(6) ) ensured the resident had the NJ Exec Order 26.4b1. LPN #5 walked over to Resident #35's tray and confirmed that he/she did not have the NJ Exec Order 26.4b1 equipment.

On 12/5/24 at 12:40 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that Resident #35 had NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and she noticed over the past NJ Exec Order 26.4b1 that he/she has had a NJ Exec Order 26.4 The U.S. FOIA (b looked at the resident's NJ Exec and confirmed that according to the NJ Exec Order 26.4b the resident should have had a NJ Exec Order 26.4b1 . At that time, she was unaware that a NJ Exec Order 26.4b1 was listed on the resident's NJ Exec Order 26.4b She further stated that should a resident require NJ Exec Order 26.4b1, the U.S. FOIA (b)(6) would fill out a communication form, and copies would go to the NJ Exec Order 2 department, nursing, and US FOIA (b)(6)

On 12/5/24 at 2:16 PM, the surveyor interviewed the U.S. FOIA (b)(6) ) who confirmed that according to the NJ Exec Order 26.4b1 Resident #35 should have had a NJ Exec Order 26.4b1 during meals.

On 12/6/24 at 11:49 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that when the food carts arrived on the unit, the nurses and CNAs passed them out. She further stated the nurses, CNAs, and anyone passing

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 810 | Continued From page 39<br>trays were supposed to check the [NJ Exec Order 26,] and that adaptive equipment should be provided. The [U.S. FOIA (b)] stated that if they do not have the adaptive equipment on the meal tray, the kitchen should be contacted so it can be obtained.<br><br>A review of the facility's "Assistance with Meals" policy, revised March 2022, included "1. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. 2. Assistance will be provided to ensure than [sic] residents can use and benefit from special eating equipment and utensils if needed. | F 810 | | |
| F 812 SS=F | NJAC 8:39-27.5 (b)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility. | F 812 | | 12/12/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 812 | Continued From page 40<br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Complaint #: NJ176956<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness.<br><br>This deficient practice was evidenced by the following:<br><br>On 12/4/24 at 9:45 AM, the surveyor, accompanied by the U.S. FOIA (b)(6) U.S. FOIA (b)(6), observed the following in the kitchen:<br><br>1. When the surveyor and the U.S. FOIA (b approached the designated handwashing sink, a dietary staff member removed items from the sink. When asked what the items were, the U.S. FOIA stated the dietary staff member removed a fork and spatula from the sink that was used to make sandwiches. The U.S. FOIA further stated that there should not be food prep items in the designated handwashing sink. There was no signage to indicate the sink was to be used for handwashing purposes only.<br><br>2. In the walk-in refrigerator, there were three metal shelving units used to store food items. The three shelving units had rust on the shelves.<br><br>3. In the dish washing area, there was a build-up of black substance in the calking between the counter and the wall. The U.S. FOIA stated the area was cleaned daily, but the dietary staff had not | F 812 | F812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>No residents were affected by the deficient practice stated in the statement of deficiencies evidenced by no resident showed signs or symptoms of infection related to items from the Kitchen.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.<br>All residents had the potential to be affected by the deficient practice stated in the statement of deficiencies<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>On 12/4/24 the items in the handwashing sink were removed and signage hung above the sink.<br>On 12/9/24 the three racks in the walk in fridge were replaced with new ones<br>On 12/6/24 The dish machine area was thoroughly cleaned and the Maintenance team recalked between the counter and the wall<br>On 12/4/24 the U.S. FOIA (b removed all plates that were chipped<br>In services were completed on 12/10/24 by the U.S. FOIA (b)(6) and U.S. FOIA (b with the Kitchen | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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|---|---|---|---|---|
| F 812 | Continued From page 41<br>gotten to cleaning the area yet.<br><br>4. In the area identified by the [U.S. FOIA] as the storage area for plates to be used for meal service, there were four ceramic meal plates that were chipped. The [U.S. FOIA] stated the chipped plates should be thrown away and removed them from the storage area.<br><br>On 12/5/24 at 9:57 AM, the surveyor interviewed the [U.S. FOIA] who stated the dietary staff were unable to remove the black substance from the dish washing area and would have to contact maintenance for assistance. The [U.S. FOIA (b)(6)] further stated the dish washing area should be kept clean to prevent contamination. When asked about the shelving units in the walk-in refrigerator, the [U.S. FOIA] stated they should not have rust because "rust is a possible contaminate." When asked about the chipped ceramic plates, the [U.S. FOIA] stated chipped dishware should not be used for the safety of residents.<br><br>On 12/9/24 at 1:27 PM, in the presence of the U.S. FOIA (b)(6) and the survey team, the surveyor notified the U.S. FOIA (b)(6) ) of the concerns in the kitchen. The [U.S. FOIA (b)(6)] stated used utensils should not be stored in the designated handwashing sink. The [U.S. FOIA (b)(6)] further stated that if there was rust on the shelving units in the walk-in refrigerator, the dietary staff should have reported it to maintenance and not stored food on those shelves until the rust was addressed. The [U.S. FOIA (b)(6)] also stated the dietary staff should have cleaned the black substance in the dish washing area or notified housekeeping and maintenance for further assistance. The [U.S. FOIA (b)(6)] added that the dietary staff should have | F 812 | staff addressing each of the concerns noted in the Statement of deficiencies<br>1. Infection Control<br>2. Dish Inspection<br>3. General cleanliness<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br>The Dietician or designee will conduct weekly audits for one month and biweekly thereafter for 2 months<br>The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 812 | Continued From page 42<br>thrown away any chipped dishware.<br><br>Review of the facility's "Handwashing, Kitchen" policy, updated 4/2024, included, "Hand washing facilities should be readily accessible and equipped with hot and cold running water, paper towels, soap, trash cans, and signage notifying employees to wash their hands."<br><br>Review of the facility's "Food Receiving and Storage" policy, revised November 2022, included, "Food services, or other designated staff, maintain clean and temperature/humidity-appropriate food storage areas at all times."<br><br>Review of the facility's "Sanitization" policy, revised November 2022, included, "All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris." Further review of the policy included, "All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning," and, "Plastic ware, china and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze are discarded." | F 812 | | |
| F 814 SS=D | NJAC 18:39-17.2(g)<br>Dispose Garbage and Refuse Properly<br>CFR(s): 483.60(i)(4)<br><br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>This REQUIREMENT is not met as evidenced | F 814 | | 12/12/24 |

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|---|---|---|---|---|
| F 814 | Continued From page 43<br>by:<br>Based on observation, interview, and review of facility documents, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to a.) keep the dumpster area free of garbage and debris and b.) have a cover over the opening of 2 of 3 dumpsters.<br><br>This deficient practice was evidenced by the following:<br><br>On 12/4/24 at 10:30 AM, the surveyor, accompanied by the U.S. FOIA (b)(6), observed the facility's designated garbage disposal area. There were three garbage dumpsters that each contained two lids. Two of the garbage dumpsters each had one lid open, exposing trash bags inside. There was also garbage on the ground between the two open garbage dumpsters which included single-use gloves, plastic water bottles, plastic packaging, single-serve juice containers, plastic cup lids, paper debris, and cardboard.<br><br>The surveyor interviewed the U.S. FOIA (b) at that time who stated the garbage dumpster lids should be closed and there should not be loose trash surrounding the garbage dumpsters.<br><br>On 12/9/24 at 12:18 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated dietary, housekeeping, and maintenance take their own trash to the dumpsters. The U.S. FO further stated that the dumpster lids should be kept closed and that there should not be trash and debris surrounding the dumpsters for "infection control reasons." | F 814 | No resident were affected by the deficient practice stated in the statement of deficiencies<br>All residents had the potential to be affected by the deficient practice stated on the (SOD) Statement of deficiencies<br>On 12/9/24 the dumpster area was cleaned Lids were covered.<br>On 12/9/24 the U.S. FOIA (b)(6) in serviced the U.S. FOIA (b)(6) on the regulation and ensuring that this is followed.<br>The Administrator will audit the Garbage area weekly for 1 month and biweekly there after for 3 months.<br>The results of the audits will be reported by the administrator to the facility monthly QAPI committee meeting for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit.<br>Compliance date 12/12/24 | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 814 | Continued From page 44<br>On 12/9/24 at 12:23 PM, the surveyor interviewed the U.S. FOIA (b)(6) ) who stated housekeeping and dietary maintained the dumpster area when they dispose of trash, but maintenance would pick up trash and debris when it was observed. The U.S. FOI further stated the dumpster lids should be kept closed and there should not be trash and debris surrounding the dumpsters "to prevent pests from the area."<br><br>On 12/9/24 at 1:27 PM, in the presence of the U.S. FOIA (b)(6) , and the survey team, the surveyor notified the U.S. FOIA (b)(6) of the dumpster area. The U.S. FOIA (b)(6) stated the dumpster area should be kept clean with the dumpster lids closed.<br><br>Review of the facility's "Sanitization" policy, revised November 2022, included, "Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered)," and, "Areas used for garbage disposal are free from odors and waste fats, and maintained to prevent pests."<br><br>Review of the facility's "Food-Related Garbage and Refuse Disposal" policy, updated April 2024, included, "Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter." | F 814 | | |
| F 868 SS=D | NJAC 18:39-19.3(b)<br>QAA Committee<br>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) | F 868 | | 12/12/24 |

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|---|---|---|---|
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|---|---|---|---|---|
| F 868 | Continued From page 45<br>§483.75(g) Quality assessment and assurance.<br>§483.75(g) Quality assessment and assurance.<br>§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br>(i) The director of nursing services;<br>(ii) The Medical Director or his/her designee;<br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br>(iv) The infection preventionist.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.<br><br>§483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of pertinent facility documents, it was determined that the | F 868 | All residents had the potential to be affected by the deficient practice stated in | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 868 | Continued From page 46<br>facility failed to ensure the required committee members, specifically the U.S. FOIA (b)(6) , was present for 1 of 4 Quality Assurance and Performance Improvement (QAPI) quarterly meetings reviewed.<br><br>This deficient practice was evidenced by the following:<br><br>On 12/4/24 at 10:10 AM, during the entrance conference with the U.S. FOIA (b)(6) , the surveyor requested the last four quarters of the QAPI sign-in sheets.<br><br>On 12/5/24 at 10:15 AM, the U.S. FO provided the last four quarters of the QAPI sign-in sheets. At that time, the surveyor requested the U.S. FO to identify the staff members that signed the sheets.<br><br>On 12/5/24 at 10:24 AM, the U.S. FOI provided the updated sign-in sheets, which revealed the U.S. FOIA (b)(6) did not sign in for the NJ Exec Order 26.4b1 QAPI meeting.<br><br>A review of the QAPI book and the QAPI minutes reflected there was no documented evidence the U.S. FOIA (b)(6) was in attendance for the NJ Exec Order 26.4b1 meeting.<br><br>On 12/9/24 at 11:33 AM, the U.S. FOIA (b)(6 stated, in the presence of the survey team, that QAPI met monthly with quarterly goals. He stated the U.S. FOIA (b)(6) and/or a physician, the U.S. FOIA (b)(6) , and the department heads attended the QAPI meetings. When asked if the U.S. FOIA (b)(6 was required to attend, he stated it was "always good" for the U.S. FOIA (b)(6 to be there. | F 868 | the (SOD)<br>No residents were effected by the deficient practice stated on the SOD<br>On 12/11/24 the U.S. FOIA (b)(6) in serviced the U.S. FOIA (b)(6) on the regulation of the U.S. FOIA (b)(6) and appropriate members required to attend the QAPI meetings<br>The U.S. FOIA (b)(6) will ensure that the regulation is followed by reviewing the QAPI minutes and sign in quarterly for 4 quarters<br>The results of the U.S. FOIA (b)(6) audits will be brought by the U.S. FOIA (b)(6) to the QAPI for 4 quarters to the QAPI committee to ensure compliance has been met.<br>Compliance date 12/12/24 | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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|---|---|
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|---|---|---|---|---|
| F 868 | Continued From page 47<br><br>On 12/9/24 at 11:38 AM, the U.S. FOIA (b)( reviewed the NJ Exec Order 26.4b1 QAPI sign-in sheet and confirmed there was no U.S. FOIA (b)( signature. The U.S. FOIA (b)( stated he could not speak to the missing signature as he was not the U.S. FOIA (b)( at that time. He stated that it was important for the U.S. FOIA (b)( to attend QAPI because the U.S. FOIA (b)( was the chairperson of the committee and ensured all concerns were followed through and presented at QAPI. The U.S. FOIA (b)( confirmed that the U.S. FOIA (b)( should have signed in. He emphasized he did not know what a QAPI would be without the U.S. FOIA (b)( present.<br><br>On 12/11/24 at 11:10 AM, the U.S. FOIA (b)( stated he did not have any additional information and was unable to comment on the previous U.S. FOIA (b)(6) attendance for the NJ Exec Order 26.4b1 QAPI meeting.<br><br>A review of the facility's "Quality Assurance and Performance Improvement (QAPI) Program - Governance Leadership" policy, updated April 2024, included, "1. The administrator, whether a member of the QAPI committee or not, is ultimately responsible for the QAPI program, and for interpreting its results and findings to the governing body. 6. The following individuals serve on the committee: a. Administrator." | F 868 | | |
| F 880 SS=F | NJAC 8:39-33.1(b)<br>Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and | F 880 | | 12/23/24 |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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|---|---|
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|---|---|---|---|---|
| F 880 | Continued From page 48 | F 880 | | |

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

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

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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|---|---|---|---|---|
| F 880 | Continued From page 49<br>circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to a.) follow appropriate infection control practices by not performing hand hygiene during the meal pass for 1 of 2 units (West Wing) observed, and b.) have a water management program in place to prevent the growth of NJ Exec Order 26.4b1 ).<br><br>The deficient practice was evidenced by the following:<br><br>On 12/5/24 at 12:09 PM, the surveyor observed the following during the meal pass on the NJ Exec Orde Wing unit: | F 880 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br>F880 Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e )(f)<br><br>Resident #34 showed no signs or symptoms of NJ Exec Order 26.4b and was not NJ Exec Order 26.4b1 by the deficient practice.<br><br>Resident #61 showed no signs or symptoms of NJ Exec Order 26.4b and was not NJ Exec Order 26.4b1 by the deficient practice. | |

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|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

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|---|---|
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|---|---|---|---|---|
| F 880 | Continued From page 50<br>Certified Nursing Assistant (CNA) #2 picked up a tray from the meal cart, brought it to room [NJ Exec Or], and set up the tray for the resident. The CNA then left the room without performing hand hygiene and picked up another tray from the meal cart, brought it to room [NJ Exec Order] and set up the tray for the resident. The [U.S. FOIA (b)] then left the room without performing hand hygiene and picked up another tray from the meal cart, brought it to room [NJ Exec Orde] and set up the tray for the resident. The [U.S. FOIA (b)] then left the room without performing hand hygiene and picked up another tray from the meal cart. The [U.S. FOIA (b)] entered Resident #34's room, put the tray on the overbed table, moved the overbed table closer to the resident with ungloved hands, put on gloves to assist the resident to a sitting position by holding the resident's hand, set up the resident's tray, and tore open a sweetener packet for the resident's coffee while still wearing gloves used to assist the resident. Wearing those same gloves, the [U.S. FOIA (b)] then went to the roommate's (Resident #61) meal tray, opened the resident's coffee, tore a sweetener packet to put in the coffee, and touched the resident's eating utensils to cut up the resident's food. The [U.S. FOIA (b)] then disposed of her gloves, left the room without performing hand hygiene, and went to the meal cart to pick up another tray.<br><br>At that time, before the [U.S. FOIA (b)] picked up another tray from the meal cart, the surveyor interviewed CNA #2. The [U.S. FOIA (b)] stated that staff were supposed to perform hand hygiene between each meal tray that was passed out to prevent the transfer of germs between residents. The [U.S. FOIA (b)] confirmed that she did not perform hand hygiene during the surveyor's observation of the meal pass. | F 880 | Upon identification of the deficient practice the [US FOIA (b)] identified was provided 1:1 education. Facility wide education was initiated.<br><br>A water management program was developed and initiated into practice .<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have to potential to be affected by the deficient practice.<br><br>The U.S. FOIA (b)(6) n 12/6/24 provided facility wide education on handwashing and hand hygiene procedures.<br><br>The Administrator will in-service the Maintenance Director on the water management program.<br><br>The U.S. FOIA (b)(6) in-serviced the U.S. FOIA (b)(6) on the water management program on 12/19/24.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br><br>The Director of Nursing and Infection Preventionist will monitor meal pass twice weekly for 4 weeks, then weekly for 2 months. The Director of Nursing and | |

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|---|---|---|---|
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| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| F 880 | Continued From page 51<br><br>On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated staff should perform hand hygiene between each meal tray that is passed out to prevent the spread of germs from resident to resident.<br><br>On 12/9/24 at 12:11 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2, who was also the U.S. FOIA (b)(6) who stated staff should perform hand hygiene before picking up the next meal tray to deliver to the next resident to prevent contamination and spreading any potential infection.<br><br>On 12/9/24 at 1:19 PM, in the presence of the U.S. FOIA (b)(6) U.S. FOIA (b)(6), and the survey team, the surveyor interviewed the U.S. FOIA (b)(6) who stated staff should perform hand hygiene when exiting each resident's room during meal pass for infection prevention. At that time, the surveyor informed the U.S. FOIA (b) of the meal pass observation and the U.S. FOIA (b) confirmed that CNA #2 should have performed hand hygiene after passing out each meal tray and should not have worn the same gloves for Resident #34 and Resident #61.<br><br>A review of the facility's "Handwashing/Hand Hygiene" policy, updated April 2024, included to use an alcohol-based hand rub, or soap and water, for the following situations: "before and after assisting a resident with meals."<br><br>2.) On 12/4/24 at 10:10 AM, during the entrance conference with the U.S. FOIA (b)(6) t | F 880 | Infection Preventionist will observe hand hygiene practices performed by 3 staff members weekly for 4 weeks, then every other week for 2 months.<br><br>The Administrator will audit the water management plan procedures completed by the Maintenance director weekly x 4 weeks then every other week for 2 months.<br>The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| F 880 | Continued From page 52<br>([redacted] the surveyor requested the facility's water management program with evidence of monitoring.<br><br>On 12/6/24 at 10:26 AM, the surveyor interviewed the U.S. FOIA (b)(6) When asked if there had been a case of [redacted] or other NJ Exec Order 26.4b1 in the facility, the [redacted] stated the facility did not have any cases.<br><br>On 12/6/24 at 12:09 PM, the surveyor interviewed the [redacted] who stated they hired an outside company for the well water (water that comes from a well, which is a hole dug into the ground to access groundwater) system. The [redacted] stated he thought the outside company completed the [redacted] testing, but confirmed it was not tested. He further stated that the facility was constantly cleaning to ensure there was "no still water." The [redacted] stated that the outside company informed him that the chemicals used helped with preventing [redacted]. He further stated the U.S. FOIA (b)(6) ) oversaw the water management program and could not fully speak to what was done.<br><br>On 12/6/24 at 12:23 PM, the surveyor interviewed the [redacted], in the presence of the [redacted] and survey team, who stated that the process for the water management was the facility had an outside company that came in and treated the water. He stated that they came to test the water every two weeks to ensure the levels, which included the salt, chlorine, nitrate, and pH for the well water, were good. When asked if there was a process for monitoring waterborne pathogens such as [redacted], the [redacted] stated there was no process and that they did not monitor for [redacted]. He further stated that he did ensure there was no | F 880 | | |

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| F 880 | Continued From page 53<br>stagnate water and that he kept a report of it.<br><br>A review of the records indicated the facility monitored the lead and copper levels. There was no documented evidence for the monitoring of waterborne pathogens.<br><br>On 12/11/24 at 10:30 AM, the U.S. FOIA (b)(6 stated, in the presence of the U.S. FOIA (b)(6) ), the U.S. FOIA (b)(6) , and the survey team, that the testing that was provided did not specifically include NJ Exec Order 26.4b1. He further stated that he spoke with the outside company that tested their well water and they informed him the usage of the chemicals would "take away NJ Exec Order 26.4b1." The U.S. FOIA (b)(6 then emphasized he just scheduled an official testing for NJ Exec Order 26.4b1. The U.S. FOIA (b)(6 confirmed that he created the water management program over the weekend ( NJ Exec Order 26. , after surveyor inquiry) since they did not have one prior.<br><br>A review of the facility's "Water Supply" policy, reviewed April 2024, included, "Purpose: to maintain a sanitary water supply and control the spread of waterborne microorganisms." | F 880 | | |
| F 881 SS=E | NJAC 8:39-19.1<br>NJAC 8:39-19.4 (m)(n)<br>Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at | F 881 | | 12/24/24 |

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| F 881 | Continued From page 54<br>a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of facility documents, it was determined that the facility failed to accurately utilize an NJ Exec Order 26.4b assessment tool for 7 of 7 residents (Resident # #11, #39, #54, #65, #70, #328, #329) reviewed that were prescribed NJ Exec Order 26.4b1 medications in the facility.<br><br>This deficient practice was evidenced by the following:<br><br>A review of the facility's Antibiotic Stewardship line list for NJ Exec Order 26.4b1 revealed the following residents were prescribed antibiotics while at the facility:<br><br>1. Resident #328 was prescribed an NJ Exec Order 26.4b1 on U.S. FOIA (b)(6). The line list further indicated that in NJ Exec Order 26.4b assessment tool was completed with NJ Exec Order 26.4b1 use criteria not met.<br><br>2. Resident #11 was prescribed an NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. The line list further indicated that an NJ Exec Order 26.4b assessment tool was completed with NJ Exec Order 26.4b1 use criteria not met.<br><br>3. Resident #329 was prescribed an NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. The line list further indicated that an NJ Exec Order 26.4b1 assessment tool was completed with | F 881 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br>F881 Antibiotic Stewardship Program CFR(s): 483.80(a)(3)<br><br>Resident #11 was NJ Exec Order 26.4b1 by the deficient practice as NJ Exec Order 26.4b1 of medication or signs of reoccurring infection occurred.<br><br>,Resident 39 was NJ Exec Order 26.4b1 by the deficient practice as NJ Exec Order 26.4b1 of medication or signs of reoccurring infection occurred<br><br>Resident 54 was not NJ Exec Order 26.4b1 by the deficient practice as NJ Exec Order 26.4b1 of medication or signs of reoccurring infection occurred<br><br>Resident 65 was NJ Exec Order 26.4b1 by the deficient practice as NJ Exec Order 26.4b1 of medication or signs of reoccurring infection occurred<br><br>Resident 70 was NJ Exec Order 26.4b1 by the deficient practice as NJ Exec Order 26.4b1 of medication or signs of reoccurring infection occurred | |

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| F 881 | Continued From page 55<br>NJ Exec Order 26.4b1 use criteria not met.<br><br>4. Resident #54 was prescribed an NJ Exec Order 26.4b1 on U.S. FOIA (b)(6) The line list further indicated that an NJ Exec Order 26.4b1 assessment tool was completed with NJ Exec Order 26.4b1 use criteria not met.<br><br>5. Resident #39 was prescribed an NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . The line list further indicated that an NJ Exec Order 26.4b1 assessment tool was completed with NJ Exec Order 26.4b1 use criteria not met.<br><br>6. Resident #65 was prescribed an NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 The line list further indicated that an NJ Exec Order 26.4b1 assessment tool was completed with NJ Exec Order 26.4b1 use criteria not met.<br><br>7. Resident #54 was prescribed an NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 and then another NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . The line list further indicated that an NJ Exec Order 26.4b1 assessment tool was completed with NJ Exec Order 26.4b1 use criteria not met.<br><br>8. Resident #70 was prescribed an NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . The line list further indicated that an NJ Exec Order 26.4b1 assessment tool was completed with NJ Exec Order 26.4b1 use criteria not met.<br><br>On 12/6/24 at 10:26 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that she worked full time as a U.S. FOIA (b)(6) ) and was the U.S. FOIA (b)(6) for the NJ Exec Ord Wing and the U.S. F . She stated that she contributed at least 20 hours a week for her role as the U.S. F The U.S. stated that she used the NJ Exec Order 26.4b1 surveillance which determined if an NJ Exec Order 26.4b1 was appropriate. She further stated that she reviewed the diagnostics | F 881 | Resident #328 was NJ Exec Order 26.4b1 by the deficient practice as NJ Exec Order 26.4b1 of medication or signs of reoccurring infection occurred<br><br>Resident 329 was NJ Exec Order 26.4b1 by the deficient practice as NJ Exec Order 26.4b1 of medication or signs of reoccurring infection occurred<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Residents who are placed on antibiotics who do not meet NJ Exec Order 26.4 criteria have the potential to be negatively affected by the deficient practice.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>On 12/12/24 The Nurse Consultant in serviced the US FOIA (b)(6) on the NJ Exec Order 26.4 policy and procedure. The Infection Preventionist will review new antibiotic orders and review for McGeer criteria. The physician will be notified if NJ Exec Order 26.4 criteria is not met.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br>The Infection Preventionist will audit the results of the antibiotic stewardship program monthly. | |

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| F 881 | Continued From page 56<br>testing and the nurses and physician's documentation to determine if the criteria was met. She stated that if the criteria was not met then she would notify the physician to see if they want to continue the [NJ Exec Order 26.4b1] When asked how the data was analyzed, the [U.S. F] stated she tracked it on the Infection Log monthly and the surveillance checklist. The [U.S. F] further stated that she did not notice any trends, but if she did, then she would notify the physicians and explain to them that the criteria was not met.<br><br>On 12/6/24 at 11:10 AM, the [U.S.] provided a copy of the Infection Logs and the infection surveillance checklist. At that time, the surveyor continued to interview the [U.S.] who stated that if a resident was started on an [NJ Exec Order 26.4b1] while at the facility and criteria was not met then the nurse should called the physician and would document it in the electronic medical record (EMR). The surveyor and the [U.S.] reviewed the Infection Log and she confirmed the 7 residents were prescribed an [NJ Exec Order 26.4b1] even though the criteria was not met. The [U.S.] acknowledged there should be documentation, but there was no documentation that physician was notified that the antibiotic did not meet the criteria for the 7 residents that were at the facility and started on an antibiotic. The [U.S. F] stated the importance of following the criteria was to prevent [NJ Exec Order 26.4b1] resistant and for the risk of NJ Exec Order 26.4b1 [redacted].<br><br>On 12/11/24 at 10:57 AM, the U.S. FOIA (b)(6) [redacted] stated, in the presence of the [U.S. FOIA (b)(6)] [redacted]) and the survey team, that for the [NJ Exec Order 26.4b1] stewardship they were going to | F 881 | The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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| F 881 | Continued From page 57<br>revamp it and ensure it was followed. The [NJ Exec O] stated that it was important to follow the criteria and that it was met so they are not overusing the [NJ Exec Order 26.4b1]<br><br>A review of the facility's "Antibiotic Stewardship" policy, updated April 2024, included, "1. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents."<br><br>A review of the facility's "Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes" policy, reviewed April 2024, included, "2. The IP or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. a. Therapy may require further review and possible changes if: (4) therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. 3. At the conclusion of the review, the provider will be notified of the review findings." | F 881 | | |
| F 883 SS=E | NJAC 8:39-19.4(d)<br>Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza | F 883 | | 12/24/24 |

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| F 883 | Continued From page 58<br>immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal | F 883 | | |

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| F 883 | Continued From page 59<br>immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that the NJ Exec Order 26.4b1 or the NJ Exec Order 26.4b1 was offered to residents upon admission to the facility for 4 of 5 residents (Resident #14, #66, #69, and #70) reviewed for NJ Exec Order 26.4b1.<br><br>This deficient practice was evidenced by the following:<br><br>Reference:<br>Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report<br><br>Pneumococcal Vaccine for Adults Aged >19 Years: Recommendations of the Advisory Committee on Immunization Practices (ACIP), United States, 2023<br>Recommendations and Reports / September 8, 2023 / 72(3);1-39<br><br>Adults aged >19 years who have received PCV13 only are recommended to receive a single dose of PCV20 at an interval >1 year after receipt of the PCV13 dose or to receive >1 dose of PPSV23 to complete their pneumococcal vaccine series.<br>-When PPSV23 is used instead of PCV20, the minimum recommended interval between PCV13 and PPSV23 administration is >8 weeks for adults with an immunocompromising condition, a | F 883 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br>F883 Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)<br><br>Resident #14 was offered the NJ Exec Order 26.4b1 updated to reflect resident□s choice.<br><br>Resident #70 was offered the NJ Exec Order 26.4b1 updated to reflect resident□s choice and administration of NJ Exec Order 26.4b1<br><br>Resident #69 was offered the NJ Exec Order 26.4b1 updated to reflect resident□s choice.<br><br>Resident #66 was offered the NJ Exec Order 26.4b1 updated to reflect resident□s choice.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Any residents who have not received the | |

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| F 883 | Continued From page 60<br>CSF leak, or a cochlear implant and >1 year for adults without these conditions. Either PCV20 or a second PPSV23 dose is recommended >5 years after the first PPSV23 dose for adults aged 19-64 years with specified immunocompromising conditions but not for adults with a CSF leak or a cochlear implant. In addition, those who received both PCV13 (at any age) and PPSV23 (no PCV20) but have not received a dose of PPSV23 at age >65 years are recommended to receive either PCV20 or a single and final dose of PPSV23 at age >65 years and >5 years since the previous PPSV23 dose.<br><br>Reference:<br>Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report<br><br>Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP) - United States, 2024-25 Influenza Season Recommendations and Reports / August 29, 2024 / 73(5);1-25<br><br>Routine annual influenza vaccination of all persons aged >6 months who do not have contraindications continues to be recommended. All persons should receive an age-appropriate influenza vaccine (one that is approved for their age)<br><br>1.) On 12/6/24 at 10:19 AM, the surveyor reviewed the medical record for Resident #14.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [redacted] | F 883 | influenza or pneumococcal vaccinations have the potential to be affected by the deficient practice.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>A facility wide audit was completed to identify any residents who were eligible for the influenza or pneumococcal vaccination.<br>The Director of Nursing and Infection preventionist educated nursing on 12/12/2024 on obtaining vaccination acceptance/declinations upon admission.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br>The Infection Preventionist will review all new admissions to obtain vaccination history and if eligible obtain consent or declination. The Infection preventionist will conduct an audit of 5 residents weekly for 4 weeks, then every other week for 2 months to ensure eligible vaccinations have been offered to residents.<br>The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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| F 883 | Continued From page 61 | F 883 | | |

NJ Exec Order 26.4b1 .

A review of the resident's NJ Exec Order 26.4b1 Audit Report, as of NJ Exec Order 26.4b1 did not include any documentation related to the NJ Exec Order 26.4b1 .

A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS included the resident was offered, but declined, the NJ Exec Order 26.4b1

On 12/6/24 at 10:39 AM, in the presence of the survey team, the surveyor interviewed the NJ Exec Order 26.4b1 who confirmed administration or declination of NJ Exec Order 26.4b1 was documented in the NJ Exec Order 26.4b1 tab (NJ Exec Order 26.4b1 Audit Report) of the resident's electronic medical record.

On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the unit managers offered the residents their NJ Exec Order 26.4b1 and obtained the consents or declinations. The U.S. FOIA (6) confirmed that NJ Exec Order 26.4b1 information was documented in the resident's electronic medical record and stated it was important to offer residents NJ Exec Order 26.4b1 to "help prevent sickness such as the NJ Exec Order 26.4b1 "

On 12/9/24 at 1:19 PM, in the presence of the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 883 | Continued From page 62 | F 883 | | |

U.S. FOIA (b)(6) ), and the survey team, the surveyor interviewed the U.S. FOIA (b)(6) who stated upon admission, the resident's NJ Exec Order 26.4b1 information was included in the admission packet to determine if the resident received or would like to receive NJ Exec Order 26.4b1. The U.S. FOIA (b) further stated that any of the nurses could obtain consent or declination for the NJ Exec Order 26.4b1 and that consents/declinations were documented in the resident's medical record. The U.S. FOIA (b) added that the importance of offering NJ Exec Order 26.4b1 was so "the resident can be NJ Exec Order 26.4b1 for anything that is possibly harmful." At that time, the surveyor informed the U.S. FOIA (b) of the missing NJ Exec Order 26.4b1 information for Resident #14, and the U.S. FOIA (b) confirmed the resident should have been offered a NJ Exec Order 26.4b1

On 12/11/24 at 9:30 AM, the U.S. FOIA (b) provided the surveyor with Resident #NJ Exec Order 26.4b1 declination which was signed on NJ Exec Order 26.4b after surveyor inquiry.

On 12/11/24 at 10:30 AM, in the presence of the U.S. FOIA (b)(6) and the survey team, the surveyor interviewed the U.S. who stated the NJ Exec Order 26.4b1 consents and declinations should have been obtained upon admission.

2.) On 12/6/24 at 10:23 AM, the surveyor reviewed the medical record for Resident #70.

A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 883 | Continued From page 63 | F 883 | | |

A review of the resident's NJ Exec Order 26.4b1 Audit Report, as of NJ Exec Order 26, included a historical NJ Exec Order 26.4b1 record that the resident received the NJ Exec Order 26.4b1 There was no other documentation of a NJ Exec Order 26.4b1 after NJ Exec Orde

A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS included the resident was offered, but NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1

On 12/6/24 at 10:39 AM, in the presence of the survey team, the surveyor interviewed the U.S. FOIA (b)(6) who confirmed administration or declination of NJ Exec Order 26.4b1 was documented in the NJ Exec Order 26.4b1 tab (NJ Exec Order 26.4b1 Audit Report) of the resident's electronic medical record.

On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the unit managers offered the residents their NJ Exec Order 26.4b1 and obtained the consents or declinations. LPN #1 confirmed that NJ Exec Order 26.4b1 information was documented in the resident's electronic medical record and stated it was important to offer residents NJ Exec Order 26.4b1 to "help prevent sickness such as the NJ Exec Order 26.4b1

On 12/9/24 at 1:19 PM, in the presence of the U.S. FOIA (b)(6)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 |
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| F 883 | | F 883 | | |

Continued From page 64

U.S. FOIA (b)(6) ), and the survey team, the surveyor interviewed the U.S. FOIA (b)(6) who stated upon admission, the resident's NJ Exec Order 26.4b1 information is included in the admission packet to determine if the resident received or would like to receive NJ Exec Order 26.4b1 The U.S. FOIA (b) further stated that any of the nurses could obtain consent or declination for the NJ Exec Order 26.4b1 and that consents/declinations were documented in the resident's medical record. The U.S. FOIA (b) added that the importance of offering NJ Exec Order 26.4b1 was so "the resident can be NJ Exec Order 26.4b1 for anything that is possibly harmful." At that time, the surveyor informed the U.S. FOIA (b) of Resident #70's NJ Exec Order 26.4b1 status, and the U.S. FOIA (b) confirmed the resident should have been offered a NJ Exec Order 26.4b1

On 12/11/24 at 9:30 AM, the U.S. FOIA (b) provided the surveyor with Resident #70's NJ Exec Order 26.4b1 consent which was signed on NJ Exec Order 26.4b after surveyor inquiry.

On 12/11/24 at 10:30 AM, in the presence of the U.S. FOIA (b)(6) , and the survey team, the surveyor interviewed the U.S. F who stated the NJ Exec Order 26.4b1 consents and declinations should have been obtained upon admission.
3.) On 12/5/24 at 12:01 PM, the surveyor reviewed the medical record for Resident #69

A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 883 | Continued From page 65<br>A review of the resident's NJ Exec Order 26.4b1 Audit Report, as of NJ Exec Order 26.4, did not include any documentation related to the NJ Exec Order 26.4b1 [redacted]<br><br>A review of the resident's admission Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4 included the resident had a Brief Interview for Mental Status score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1 [redacted]. Further review of the MDS included the resident was offered, but declined, the NJ Exec Order 26.4b1.<br><br>On 12/11/24 at 9:30 AM, the U.S. FOIA (b)(6) provided the surveyor with Resident #69's NJ Exec Order 26.4b1 [redacted] consent which was signed on U.S. FOIA (b)(6) after surveyor inquiry.<br><br>4.) On 12/5/24 at 9:59 AM, the surveyor reviewed the medical record for Resident #66.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1 [redacted].<br><br>A review of the resident's NJ Exec Order 26.4b1 Audit Report, as of NJ Exec Order 26.4 did not include any | F 883 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 883 | Continued From page 66 | F 883 | | |

documentation related to the NJ Exec Order 26.4b1 [redacted].

A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident's NJ Exec Order 26.4b1 [redacted] Further review of the MDS revealed that both the NJ Exec Order 26.4b1 [redacted] were not administered and were not offered.

A review of the resident's quarterly MDS, dated NJ Exec Order 26 [redacted], included the resident had a BIMS score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS revealed that both the NJ Exec Order 26.4b1 [redacted] were offered and declined.

On 12/5/24 at 1:19 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that she had worked at the facility since NJ Exec Order 26.4b1 [redacted]. The U.S. F [redacted] stated that she reviewed the resident's admission assessments and their medical records to determine the resident's NJ Exec Order 26.4b1 status. The NJ E [redacted] stated that she had called the resident's responsible party to determine if the resident had previously received the NJ Exec Order 26.4b1 [redacted], but did not document the call and had not heard back. The U.S. [redacted] stated that she was unable to find any NJ Exec Order 26.4b1 history for the resident in the NJ Exec Order 26.4b1 data base, hospital records or under the NJ Exec Order 26.4b1 tab in the resident's EHR. The U.S. [redacted] stated there was no data to be found for the resident to indicate that the resident's NJ Exec Order 26.4b1 status was previously assessed or

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 883 | Continued From page 67 | F 883 | | |

if the resident was offered the NJ Exec Order 26.4b1 admission/readmission or when they were offered at the facility during NJ Exec Order 26.4 clinics.

The surveyor reviewed the resident's past four Admission/Readmission Evaluations and the NJ Exec Order 26.4b1 sections were incomplete and failed to indicate if the resident had previously received the NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 .

On 12/5/24 at 2:08 PM, the surveyor interviewed the U.S. FOIA (b)(6) ) who stated the admission nurse was responsible to determine if the resident had already received the NJ Exec Order 26.4b1 The U.S. FOIA (b) stated the U.S. was responsible to ensure that the resident's NJ Exec Order 26.4b1 status was accurately reflected on the NJ Exec Order 26.4b1 Audit Report. The U.S. FOIA (b) further stated the U.S. should have documented attempts to contact the resident's family in the resident's EHR.

On 12/6/24 at 11:42 AM, the surveyor interviewed the U.S. FOIA (b)(6) , via telephone, who stated that she worked at the facility since NJ Exec Order 26. . The U.S. FOIA (b)(6) stated she reviewed the resident's historical NJ Exec Order 26.4b1 history in the resident's EHR and only noted a historical NJ Exec Order 26.4b1 testing. The U.S. FOIA (b)(6) stated that she documented that the NJ Exec Order 26.4b1 status as offered and declined, and, "unfortunately, I did just copy the information from the previous MDS." The U.S. FOIA (b)(6) stated that she should have looked in the resident's EHR and attempted to find a NJ Exec Order 26.4b1 .

On 12/9/24 at 1:24 PM, The surveyor interviewed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 883 | | F 883 | | |

Continued From page 68

the [U.S. FOIA (b)] in the presence of the [U.S. FOIA (b)(6)] and the survey team. The [U.S. FOIA (b)] stated that it was important to be [NJ Exec Order 26.4b1] in order to prevent anything that may be hurtful to the resident. The [U.S. FOIA (b)] stated the resident should have been offered the [NJ Exec Order 26.4b1] and the [NJ Exec Order 26.4b1] if they were a resident during the time they were offered.

On 12/11/24 at 9:31 AM, the [U.S. FOIA (b)] provided the surveyor with an Informed Consent for [NJ Exec Order 26.4b1] and both consents were [NJ Exec Order 26.] by the resident on 12/9/24, after surveyor inquiry.

A review of the facility's "Pneumococcal Vaccine" policy, updated February 2024, included, "Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series unless medically contraindicated or the resident has already been vaccinated," and, "Administration of the pneumococcal vaccines or revaccination will be made in accordance with current Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) recommendations at the time of the vaccination."

A review of the facility's "Influenza Vaccine" policy, updated April 2024, included, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote benefits associated with vaccinations against influenza.
...Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 883 | Continued From page 69<br>medically contraindicated or the resident or employee has already been immunized.<br>...Administration of the influenza vaccine will be made in accordance with current centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) recommendations at the time of vaccination. | F 883 | | |
| F 887 SS=E | NJAC 8:39-19.4 (i)<br>COVID-19 Immunization<br>CFR(s): 483.80(d)(3)(i)-(vii)<br><br>§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:<br>(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;<br>(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;<br>(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;<br>(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects | F 887 | | 12/24/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 887 | Continued From page 70<br>associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;<br>(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;<br>(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and<br>(B) Each dose of COVID-19 vaccine administered to the resident; or<br>(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and<br>(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:<br>(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;<br>(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and<br>(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to offer residents an updated NJ Exec Order 26.4b1 for 4 of 5 residents (Resident #14, #66, #69, and #70) reviewed for NJ Exec Order 26.4b1 | F 887 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br>F887 COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 887 | Continued From page 71<br>This deficient practice was evidenced by the following:<br><br>Reference:<br>Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report<br><br>Use of COVID-19 Vaccines for Persons Aged >6 Months: Recommendations of the Advisory Committee on Immunization Practices (ACIP) - United States, 2024-2025<br>Weekly / September 19, 2024 / 73(37);819-824<br><br>On June 27, 2024, the Advisory Committee on Immunization Practices recommended 2024-2025 COVID-19 vaccination with a Food and Drug Administration (FDA)-authorized or approved vaccine for all persons aged >6 months. In August 2024, the FDA approved and authorized the Omicron JN.1 lineage (JN.1 and KP.2), 2024-2025 COVID-19 vaccines by Moderna and Pfizer-BioNTech (KP.2 strain) and Novavax (JN.1 strain).<br><br>Persons aged >12 years without moderate to severe immunocompromise need 1 dose of 2024-2025 COVID-19 vaccine (Moderna, Novavax, or Pfizer-BioNTech) to be up to date. Persons aged >12 years who have not previously received any COVID-19 vaccines and choose to get Novavax should receive 2 doses of the 2024-2025 Novavax vaccine.<br><br>1.) On 12/6/24 at 10:19 AM, the surveyor reviewed the medical record for Resident #14.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses | F 887 | Resident #14 was offered the [redacted] was updated to reflect resident's choice.<br><br>Resident #70 was offered the [redacted] was updated to reflect resident's choice and administration of [redacted]<br><br>Resident #69 was offered the [redacted] was updated to reflect resident's choice.<br><br>Resident #66 was offered the [redacted] was updated to reflect resident's choice.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Any residents who have not received the COVID-19 vaccination have the potential to be affected by the deficient practice.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>A facility wide audit was completed to identify any residents who were eligible for the COVID-19 vaccination.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 |
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| F 887 | Continued From page 72<br>which included, but were not limited to: NJ Exec Order 26.4t [redacted]<br><br>A review of the resident's NJ Exec Order 26.4b1 Audit Report, as of NJ Exec Order 26.4, included a historical NJ Exec Order 26.4b1 record that the resident received a [redacted] (NJ Exec Order 26.4 NJ Exec Order 26.4 NJ Exec Order 26.4b1 and NJ Exec Order 26.4 (NJ Exec Order 26.4b1 There was no documentation that the resident received or declined an updated NJ Exec Order 26.4b1 [redacted].<br><br>A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec [redacted], which indicated the resident's NJ Exec Order 26.4b1 [redacted].<br><br>On 12/6/24 at 10:39 AM, in the presence of the survey team, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]) who confirmed administration or declination of NJ Exec Order 26.4b1 was documented in the NJ Exec Order 26.4b1 tab (NJ Exec Order 26.4b1 Audit Report) of the resident's electronic medical record.<br><br>On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the unit managers offered the residents their NJ Exec Order 26.4b1 [redacted] and obtained the consents or declinations. The U.S. FOIA (b) confirmed that NJ Exec Order 26.4b1 information was documented in the resident's electronic medical record and stated it was important to offer residents NJ Exec Order 26.4b1 to "help prevent sickness such as the NJ Exec Order 26.4b1, or | F 887 | The Infection Preventionist will review all new admissions to obtain vaccination history and if eligible obtain consent or declination. The Infection preventionist will conduct an audit of 5 residents weekly for 4 weeks, then every other week for 2 months to ensure eligible vaccinations have been offered to residents.<br>The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| F 887 | Continued From page 73<br>NJ Exec Order 26.4b1 ."<br><br>On 12/9/24 at 1:19 PM, in the presence of the U.S. FOIA (b)(6) ), and the survey team, the surveyor interviewed the U.S. FOIA (b)(6) who stated upon admission, the resident's NJ Exec Order 26.4b1 information is included in the admission packet to determine if the resident received or would like to receive NJ Exec Order 26.4b1 The U.S. FOIA (b) further stated that any of the nurses could obtain consent or declination for the NJ Exec Order 26.4b1 and that consents/declinations were documented in the resident's medical record. The U.S. FOIA (b) added that the importance of offering NJ Exec Order 26.4b1 was so "the resident can be NJ Exec Order 26.4b1 for anything that is possibly harmful." At that time, the surveyor informed the U.S. FOIA (b) of Resident #14's NJ Exec Order 26.4b1 status, and the U.S. FOIA (b) confirmed the resident should have been offered an updated NJ Exec Order 26.4b1.<br><br>On 12/11/24 at 9:30 AM, the U.S. FOIA (b) provided the surveyor with Resident #14's NJ Exec Order 26.4b1 which was signed on NJ Exec Order 26.4b1, after surveyor inquiry.<br><br>On 12/11/24 at 10:30 AM, in the presence of the U.S. FOIA (b)(6), and the survey team, the surveyor interviewed the U.S. F who stated the NJ Exec Order 26.4b1 consents and declinations should have been obtained upon admission.<br><br>2.) On 12/6/24 at 10:23 AM, the surveyor reviewed the medical record for Resident #70.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: | F 887 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 887 | | F 887 | | |

Continued From page 74

NJ Exec Order 26.4b1

A review of the resident's NJ Exec Order 26.4b1 Audit Report, as of NJ Exec Order 26., included a historical NJ Exec Order 26.4b1 record that the resident received a NJ Exec Order 26.4b1 NJ Exec Order 26.4NJ Exec Order 26.4b (NJ Exec Order 26.4NJ Exec Order 26 (NJ Exec Order 26.4b1 and NJ Exec Order 26 (NJ Exec Order 26.4b1 There was no documentation that the resident received or declined an updated NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 after NJ Exec Orde

A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1.

On 12/6/24 at 10:39 AM, in the presence of the survey team, the surveyor interviewed the U.S. FOIA (b)(6) who confirmed administration or declination of NJ Exec Order 26.4b1 was documented in the NJ Exec Order 26.4b1 tab (NJ Exec Order 26.4b1 Audit Report) of the resident's electronic medical record.

On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the unit managers offered the residents their NJ Exec Order 26.4b1 and obtained the consents or declinations. LPN #1 confirmed that NJ Exec Order 26.4b1 information was documented in the resident's electronic medical record and stated it was important to offer residents NJ Exec Order 26.4b1 to "help prevent sickness such as the NJ Exec Order 26.4b1 ."

On 12/9/24 at 1:19 PM, in the presence of the U.S. FOIA (b)(6) the U.S. FOIA (b)(6)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 887 | | F 887 | | |

Continued From page 75

U.S. FOIA (b)(6) ), and the survey team, the surveyor interviewed the U.S. FOIA (b)(6) who stated upon admission, the resident's NJ Exec Order 26.4b1 information is included in the admission packet to determine if the resident received or would like to receive NJ Exec Order 26.4b1 The U.S. FOIA (b further stated that any of the nurses could obtain consent or declination for the NJ Exec Order 26.4b1 and that consents/declinations were documented in the resident's medical record. The U.S. FOIA (b added that the importance of offering NJ Exec Order 26.4b1 was so "the resident can be NJ Exec Order 26.4b1 for anything that is possibly harmful." At that time, the surveyor informed the U.S. FOIA (b of Resident #70's NJ Exec Order 26.4b1 status, and the U.S. FOIA (b confirmed the resident should have been offered an updated NJ Exec Order 26.4b1.

On 12/11/24 at 9:30 AM, the U.S. FOIA (b)(6 provided the surveyor with Resident #70's NJ Exec Order 26.4b1 consent which was signed on NJ Exec Order 26.4b1, after surveyor inquiry.

On 12/11/24 at 10:30 AM, in the presence of the U.S. FOIA (b)(6) , and the survey team, the surveyor interviewed the U.S. F who stated the NJ Exec Order 26.4b1 NJ Exec Order 26.4b consents and declinations should have been obtained upon admission.
3.) On 12/5/24 at 12:01 PM, the surveyor reviewed the medical record for Resident #69

A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, NJ Exec Order 26.4b1 .

A review of the resident's NJ Exec Order 26.4b1 Audit Report, as of NJ Exec Order 26.4b, did not include any

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 |
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| F 887 | Continued From page 76<br>documentation related to the NJ Exec Order 26.4b1.<br><br>A review of the resident's admission Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1, included the resident had a Brief Interview for Mental Status score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1 NJ Exec O<br><br>On 12/11/24 at 9:30 AM, the DON provided the surveyor with Resident #69's NJ Exec Order 26.4b1 declination which was signed on NJ Exec Order 26.4b1 after surveyor inquiry.<br>4.) On 12/5/24 at 9:59 AM, the surveyor reviewed the medical record for Resident #66.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1<br><br>A review of the resident's NJ Exec Order 26.4b1 Audit Report, as of NJ Exec Order 26.4b1, did not include any documentation related to the NJ Exec Order 26.4b1 administration.<br><br>A review of the resident's quarterly MDS, dated NJ Exec Order 26.4b1, included the resident had a BIMS score of NJ Exec Order 26.4b1, which indicated the resident's | F 887 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 887 | Continued From page 77 | F 887 | | |

NJ Exec Order 26.4b1. Further review of the MDS revealed that the resident's NJ Exec Order 26.4b1 was not up to date.

The surveyor reviewed the resident's past four Admission/Readmission Evaluations and the NJ Exec Order 26.4b1 sections were incomplete and failed to indicate if the resident had previously received the NJ Exec Order 26.4b1.

On 12/5/24 at 2:08 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated the admission nurse was responsible to determine if the resident had already received the NJ Exec Order 26.4b1. The U.S. FOIA (b) stated the U.S. was responsible to ensure that the resident's NJ Exec Order 26.4b1 status was accurately reflected on the NJ Exec Order 26.4b1 Audit Report. The U.S. FOIA (b) further stated the U.S. should have documented attempts to contact the resident's family in the resident's EHR.

On 12/5/24 at 1:19 PM, the surveyor interviewed the U.S. FOIA (b)(6), who stated that she had worked at the facility since NJ Exec Order 26.4b1. The U.S. FO stated that she reviewed the resident's admission assessments and their medical records to determine the resident's NJ Exec Order 26.4b1 status. The U.S. stated that she had called the resident's responsible party to determine if the resident had previously received the NJ Exec Order 26.4b1 but did not document the call and had not heard back. The U.S. stated that she was unable to find any NJ Exec Order 26.4b1 history for the resident in the NJ Exec Order 26.4b1 data base, hospital records, or under the NJ Exec Order 26.4b1 tab in the resident's EHR. The U.S. stated there was no data to be found for the resident to indicate that the resident's NJ Exec Order 26.4b1 status was previously assessed or if the resident was offered the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 887 | Continued From page 78 | F 887 | | |

NJ Exec Order 26.4b1 upon admission/readmission.

On 12/6/24 at 11:42 AM, the surveyor interviewed the U.S. FOIA (b)(6), via telephone, who stated that she worked at the facility since NJ Exec Order 26.4b1. The MDS stated she reviewed the resident's historical NJ Exec Order 26.4b1 history in the resident's EHR and only noted a NJ Exec Order 26.4b1 testing. The U.S. FOIA (b)(6) stated, "unfortunately, I did just copy the information from the previous MDS." The U.S. FOIA (b)(6) stated that she should have looked in the resident's EHR and attempted to find NJ Exec Order 26.4b1 information.

On 12/9/24 at 1:24 PM, the surveyor interviewed the U.S. FOIA (b) in the presence of the U.S. FOIA (b)(6) and the survey team. The U.S. FOIA (b) stated that it was important to be NJ Exec Order 26.4b1 in order to prevent anything that may be hurtful to the resident. The U.S. FOIA (b) stated the resident should have been offered the NJ Exec Order 26.4b1

On 12/11/24 at 9:31 AM, the U.S. FOIA (b) provided the surveyor with a NJ Exec Order 26.4b1 consent with documented resident NJ Exec Order 2 that was signed by the resident on NJ Exec Order 26, after surveyor inquiry.

A review of the facility's "COVID-19 Vaccination" policy, updated April 2024, included, "When COVID-19 vaccine is available to the facility, each resident and staff member who has not already been immunized and does not have medical contraindications will be offered the vaccine." Further review of the policy included, "Prior to vaccination, informed consent will be obtained," and, "The resident, resident representative, or staff member has the opportunity to accept or refuse the COVID-19 vaccine and change their

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| F 887 | Continued From page 79<br>decision about vaccination at any time. Refusal of the vaccine shall be documented."<br><br>NJAC 8:39-19.4(a) | F 887 | | |
| F 921 SS=E | Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)<br><br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain a safe and sanitary medication storage room. This deficient practice was identified in 1 of 2 medication storage rooms ([redacted] Wing med room) and was evidenced as follows:<br><br>On 12/5/2024 at 9:04 AM, the surveyor entered the medication (med) storage room located on the [redacted] Wing, accompanied by Licensed Practical Nurse (LPN) #1; upon entering, there was a musty odor and the following was observed:<br><br>The floor tile was discolored with stains and small particles in various areas.<br><br>The floor was raised and buckled in the area closest to the left wall.<br><br>There was a crack extending across the ceiling.<br><br>There was piping that was detached piping laying | F 921 | All residents on West Unit had the potential to be affected by the deficient practice stated in the (SOD)<br>No residents were negatively affected by the deficient practice stated in the statement of deficiencies evidenced by no resident showed signs or symptoms of infection related to items from the medication room<br>On 12/9/24 The [redacted] replaced the broken sink. On 12/11/24 the floor was dried, aired out and repaired<br>On 12/10 the [redacted] in serviced the [redacted] on the regulation to ensure safe, functional, sanitary environment in the facility<br>The Maintenance director will audit the med rooms weekly for one month and biweekly thereafter for 3 months<br>The results of the Audit will be brought to the monthly QAPI committee to determine if compliance was met.<br>Compliance date 12/12/24 | 12/12/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 921 | Continued From page 80<br>on the floor in front of the sink.<br><br>In the cabinet under the sink, there was a moist soiled white blanket containing brown stains and debris. The lower bilateral sides of the interior of the cabinet were discolored grayish black.<br><br>On 12/5/2024 at 10:54 AM, the surveyor interviewed the[redacted] who stated he was responsible for repairing the med room piping and floor.<br>He stated that the pipes in the med storage room broke about three weeks ago and that he ordered the parts. He further stated he was not at work for about a week after he ordered the parts and that while he was out nothing was done since he was the only maintenance person on staff.<br><br>On 12/05/24 at 2:29 PM, the surveyor conducted a follow-up visit to the[redacted] Wing med storage room, accompanied by LPN #3 and LPN/UM #2. When LPN#3 turned on the faucet, water came out of the pipe under the sink and onto the white blanket. There was no signage indicating that the sink was not in working condition.<br><br>At that time, LPN/UM #2 stated that the med room sink was nonfunctional. When asked if there was any hand sanitizer, she replied, "no" there was no hand sanitizer in the med storage room.<br><br>On 12/6/2024 at 12:14 PM, the surveyor interviewed LPN/UM#1 , who stated the sink has been nonfunctional for about a month. She further stated something under the sink was cracked or broken because when she washed her hands she could hear water dripping under the sink. She also stated that the facility knew | F 921 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 921 | Continued From page 81 | F 921 | | |

that the floor was "pushing in" and "squishy."

On 12/6/2024 at 1:25 PM, the surveyor conducted a follow-up interview with LPN #1, who stated when she washed her hands at the sink in the med storage room, she would hear water dripping under the sink. She then stated that the floor had been "soft and wet" for months. She further stated that the [redacted] was informed, but she did not recall when he was notified.

On 12/6/24 at 1:33 PM, the surveyor interviewed LPN #3, who stated that she has not been washing her hands in the med room for about one month due to the sink being out of order. She further stated that she was unsure of when the water leaked onto the floor.

On 12/6/2024 at 1:39 AM, the surveyor conducted an interview with LPN/UM #2, who stated that since September there has been a leak onto the med storage floor and the damage progressed. She further stated, "You can tell it was wet in there, and you could see that the tiles had obviously gotten wet." She also stated that there was a maintenance log and and all issues where documented on the maintenance log.

On 12/9/2024 at 9:03 AM, the surveyor conducted a follow-up interview with the [redacted] When asked if the condition of the med storage room floor was reported to him, he stated that he received reports related to "some water on the floor." The [redacted] further stated that the floor, the faucet and the cabinet should be maintained in good repair.

On 12/9/2024 at 2:26 PM, the surveyor interviewed the [redacted] who

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (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 921 | Continued From page 82 | F 921 | | |

stated that medications should be stored in a clean, dry, organized, temperature-controlled, and sanitary environment. She stated that she toured the medication storage rooms once per month and her last visit was on 12/5/24. She further stated when she toured the [redacted] Wing med storage room this month, she noticed that there was "something going on" and told the facility that it was unacceptable. When asked, what would be her recommendation if the med storage room had a leak, she replied that the facility would have to rectify that immediately, because if an air quality test were to be done, it would not be considered a dry cool room.

A review of the facility's " Storage of Medications " policy updated April 2024 included "3. The nursing staff is responsible for maintaining medication storage and preparation areas clean, safe, and sanitary.

A review of the facility's "Maintenance Service" undated policy included, "Maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards."

NJAC 8:39-31.4(a)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061704 | A. BUILDING: _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BIG OAK REHABILITATION AND HEALTHCARE | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | Initial Comments<br><br>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<br><br>The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Complaint #: NJ169913<br><br>Based on interview and review of pertinent facility documentation, it was determined that the facility failed to a.) maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, for 1 of 1 week of complaint staffing and 2 of 2 weeks of staffing prior to the recertification survey dated 12/11/24 and b.) have two (2) trained and appointed designated staff members and the facility staff within the required time frames for the Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive (LGBTQI+) and Human | S 560 | No residents were effected by the deficient practice identified in the SOD.<br>All Residents of the facility have the potential to be affected by the deficient practice noted in the SOD.<br>A staffing and culture committee including Director of Nursing, Staffing Coordinator, and Administrator/designees has been convened on 12/16/24 and will meet four times a week to review retention efforts, open positions, recruitment tactics, and changes to improve outcomes staffing for upcoming week.<br>The facility has contracts in place with multiple staffing agencies as an effort to provide additional staff when needed. | 1/9/25 |

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

Electronically Signed | 12/31/24

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061704 | A. BUILDING: _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| S 560 | Continued From page 1<br><br>Immunodeficiency Virus positive [HIV+: a virus that attacks cells that help the body fight infection]) program.<br><br>This deficient practice was evidenced by the following:<br><br>1.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:<br><br>One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift.<br><br>One (1) 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<br><br>One (1) 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.<br><br>A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following:<br><br>1. For the week of Complaint staffing from 12/24/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 7 of 7 | S 560 | The facility has secured an outside recruitment company to oversee recruitment tactics, open position and they participate in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes. Contract staff utilization is reviewed bi- weekly to identify trends and opportunities. The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, Increased utilization of PRN staff, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Rate adjustments, Benefit adjustments and Contract staff utilization. On 12/10 The Director of Nursing as well as the Administrator in serviced the staffing coordinator on the regulation maintaining at least the minimum direct care staff to resident ratios<br><br>The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for two months and then quarterly.<br><br>The results of Resident Council minutes as well as recruitment data will be reviewed by the Administrator or designee at the quarterly QAPI meeting.<br><br>Part B<br><br>No residents were Affected by the deficient practice stated in the statement of deficiencies. | |

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|---|---|---|---|
| | 061704 | A. BUILDING: _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BIG OAK REHABILITATION AND HEALTHCARE | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| S 560 | Continued From page 2<br>day shifts as follows:<br><br>-12/24/23 had 5 CNAs for 65 residents on the day shift, required at least 8 CNAs.<br>-12/25/23 had 5 CNAs for 65 residents on the day shift, required at least 8 CNAs.<br>-12/26/23 had 7 CNAs for 65 residents on the day shift, required at least 8 CNAs.<br>-12/27/23 had 7 CNAs for 65 residents on the day shift, required at least 8 CNAs.<br>-12/28/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.<br>-12/29/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.<br>-12/30/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.<br><br>2. For the 2 weeks of staffing prior to survey from 11/17/2024 to 11/30/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows:<br><br>-11/17/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs.<br>-11/18/24 had 9 CNAs for 77 residents on the day shift, required at least 10 CNAs.<br>-11/19/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs.<br>-11/20/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs.<br>-11/21/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs.<br>-11/22/24 had 9 CNAs for 77 residents on the day shift, required at least 10 CNAs.<br><br>-11/24/24 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs.<br>-11/25/24 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs.<br>-11/26/24 had 7 CNAs for 76 residents on the day | S 560 | All Residents had the potential to be affected by the lack of training of the staff.<br>The facility designated on 12/7/24 a second representative of the front-line staff member who will be the designated staff members for LGBTGI+ education and training.<br>Education has been initiated and will be provided by a contracted organization to all the staff in the facility. Educated will be completed by or before by 1/9/2025.<br><br>The NHA/designee will ensure the facility is in compliance with monthly audits and in-services and will report to the monthly quality assurance committee for follow up. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061704 | A. BUILDING: _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BIG OAK REHABILITATION AND HEALTHCARE | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| S 560 | Continued From page 3<br>shift, required at least 9 CNAs.<br>-11/27/24 had 7 CNAs for 76 residents on the day shift, required at least 9 CNAs.<br>-11/29/24 had 8 CNAs for 79 residents on the day shift, required at least 9 CNAs.<br><br>On 12/9/24 at 12:20 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one direct care staff for 10 residents on the 3:00 PM - 11:00 PM shift, and one direct care staff for 14 residents on the 11:00 PM - 7:00 AM shift.<br><br>On 12/9/24 at 2:14 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one direct care staff for 10 residents on the 3:00 PM - 11:00 PM shift, and one direct care staff for 14 residents on the 11:00 PM - 7:00 AM shift.<br><br>2.) Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021, and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking. | S 560 | | |

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| S 560 | Continued From page 4<br><br>Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities").<br><br>The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status.<br><br>Prohibited Actions<br>The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status:<br><br>1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility;<br><br>2. Denying a request by residents to share a room;<br><br>3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 ( e) (5);<br><br>4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this | S 560 | | |

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| S 560 | Continued From page 5 | S 560 | | |

paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity;

5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice;

6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices;

7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations;

8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and

9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10( c)(6).

Resident Records
Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident.

Confidentiality

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| S 560 | Continued From page 6<br><br>The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed.<br><br>Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties.<br><br>Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility.<br><br>Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling.<br><br>Violations | S 560 | | |

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| BIG OAK REHABILITATION AND HEALTHCARE | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| S 560 | Continued From page 7<br>A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action.<br><br>Training<br>Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey.<br><br>The required training shall address:<br>1. Caring for LGBTQI+ seniors and seniors living with HIV;<br><br>2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status;<br><br>3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV;<br><br>4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns;<br><br>5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ | S 560 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BIG OAK REHABILITATION AND HEALTHCARE | 849 BIG OAK ROAD PITTSGROVE, NJ 08318 |

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| S 560 | Continued From page 8<br>community;<br><br>6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and<br><br>7. An overview of the provisions of LGBTQI+ Law.<br>Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training.<br><br>On 12/4/24 at 10:10 AM, during the entrance conference with the Licensed Nursing Home Administrator (LNHA) and the Nurse Consultant (NC), the surveyor requested a copy of the two certified staff members and the most recent training for all staff members related to LGBTQI+.<br><br>On 12/6/24 at 11:00 AM, the Nurse Consultant (NC) provided the Director of Social Work (DSW) certification. At that time, the NC stated they could only find the one certification for the LGBTQI+<br><br>On 12/6/24 at 12:07 PM, the surveyor interviewed the NC who stated that they did not have a policy for LGBTQI+ but that they followed the regulations. She stated that the previous LNHA informed the current LNHA the education was completed, but they would have to find it.<br><br>On 12/9/24 at 12:05 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that they had one staff that was trained but they did not have the second staff | S 560 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 560 | Continued From page 9<br>member. He stated when he became the LNHA he was informed when he started that it was completed but he was unable to obtain any certification. The LNHA then stated he did not believe there was any staff education related to LGBTQI+. He stated that he scheduled a Certified Nursing Assistant (CNA) to take the training. When asked if the one certified staff member provided training to the entire staff, he stated the one certified did not conduct any staff training to the entire staff. The LNHA stated that it was important to have the two certified staff members and to have the entire staff educated on LGBTQI+ to ensure they were following the regulations and were inclusive of all residents.<br><br>On 12/11/24 at 10:58 AM, the LNHA stated, in the presence of the NC, the Director of Nursing (DON), and the survey team, that the LGBTQI+ staff education was completed and the second person was scheduled to take the test, after surveyor inquiry.<br><br>The facility was unable to provide a policy related to LGBTQI+. | S 560 | | |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 061704 Y1 | A. Building<br>B. Wing Y2 | 1/13/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD<br>PITTSGROVE, NJ 08318 |

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 | 01/09/2025 | 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 |
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| 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 | |
|---|---|
| 12/11/2024 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |

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 |
|---|---|---|
| 315014 Y1 | A. Building<br>B. Wing Y2 | 1/13/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD<br>PITTSGROVE, NJ 08318 |

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 F0584 | Correction | ID Prefix F0600 | Correction | ID Prefix F0623 | Correction |
| Reg. # 483.10(i)(1)-(7) | Completed | Reg. # 483.12(a)(1) | Completed | Reg. # 483.15(c)(3)-(6)(8) | Completed |
| LSC | 12/24/2024 | LSC | 12/17/2024 | LSC | 12/12/2024 |
| ID Prefix F0656 | Correction | ID Prefix F0658 | Correction | ID Prefix F0686 | Correction |
| Reg. # 483.21(b)(1)(3) | Completed | Reg. # 483.21(b)(3)(i) | Completed | Reg. # 483.25(b)(1)(i)(ii) | Completed |
| LSC | 12/16/2024 | LSC | 12/12/2024 | LSC | 12/18/2024 |
| ID Prefix F0698 | Correction | ID Prefix F0761 | Correction | ID Prefix F0810 | Correction |
| Reg. # 483.25(l) | Completed | Reg. # 483.45(g)(h)(1)(2) | Completed | Reg. # 483.60(g) | Completed |
| LSC | 12/12/2024 | LSC | 12/12/2024 | LSC | 12/12/2024 |
| ID Prefix F0812 | Correction | ID Prefix F0814 | Correction | ID Prefix F0868 | Correction |
| Reg. # 483.60(i)(1)(2) | Completed | Reg. # 483.60(i)(4) | Completed | Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) | Completed |
| LSC | 12/12/2024 | LSC | 12/12/2024 | LSC | 12/12/2024 |
| ID Prefix F0880 | Correction | ID Prefix F0881 | Correction | ID Prefix F0883 | Correction |
| Reg. # 483.80(a)(1)(2)(4)(e)(f) | Completed | Reg. # 483.80(a)(3) | Completed | Reg. # 483.80(d)(1)(2) | Completed |
| LSC | 12/23/2024 | LSC | 12/24/2024 | LSC | 12/24/2024 |

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

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 |
|---|---|---|
| 315014 Y1 | A. Building<br>B. Wing Y2 | 1/13/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD<br>PITTSGROVE, NJ 08318 |

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 F0887 | Correction | ID Prefix F0921 | Correction | | |
| Reg. # 483.80(d)(3)(i)-(vii) | Completed | Reg. # 483.90(i) | Completed | | |
| LSC | 12/24/2024 | LSC | 12/12/2024 | | |

| 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? |
|---|---|
| 12/11/2024 | ☐ YES ☐ NO |

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 |
|---|---|---|
| 315014 Y1 | A. Building<br>B. Wing Y2 | 1/13/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD<br>PITTSGROVE, NJ 08318 |

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 F0584 | Correction | ID Prefix F0812 | Correction | ID Prefix | Correction |
| Reg. # 483.10(i)(1)-(7) | Completed | Reg. # 483.60(i)(1)(2) | Completed | Reg. # | Completed |
| LSC | 12/24/2024 | LSC | 12/12/2024 | 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 | |
| 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? |
|---|---|
| 12/11/2024 | ☐ YES ☐ NO |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 061704 Y1 | A. Building<br>B. Wing Y2 | 1/13/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD<br>PITTSGROVE, NJ 08318 |

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 | 01/09/2025 | 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 | |
|---|---|
| 12/11/2024 | ☐ 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 |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BIG OAK REHABILITATION AND HEALTHCARE CENTER** | **849 BIG OAK ROAD**<br>**PITTSGROVE, NJ 08318** |

| (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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by the New Jersey Department of Health on 12/05/24 and 12/06/24, the facility is NOT 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 | | |
| E 009 SS=F | Local, State, Tribal Collaboration Process<br>CFR(s): 483.73(a)(4)<br><br>§403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:]<br><br>(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. *<br><br>* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency | E 009 | | 12/26/24 |

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

Electronically Signed | 12/31/2024

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 |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BIG OAK REHABILITATION AND HEALTHCARE CENTER** | **849 BIG OAK ROAD**<br>**PITTSGROVE, NJ 08318** |

| (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 |
|---|---|---|---|---|
| E 009 | Continued From page 1<br>preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review on 12/06/24 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that a copy of the facility's Emergency Preparedness Plan and Program (EPP) was sent to the local and county Office of Emergency Management (OEM) for annual review in accordance with the Code of Federal Regulations (CFR) 483.73 LTC facilities. This deficient practice had the potential to affect 78 residents and was evidenced by:<br><br>Record review at 1:30 PM revealed there was no documentation of the emergency preparedness plan collaboration and cooperative planning or annual review including the local or county OEM. No further documentation was provided.<br><br>In an interview at the time, the U.S. FOIA (b)(6) confirmed the review and stated he would email documentation. No further documentation was provided.<br><br>A Life Safety Code exit conference was attempted on 12/06/24 but the U.S. FOIA (b)(6) [redacted] had left for the day and were not available.<br><br>NJAC 8:39-31.2(e), 31.6(f), 31.6(h), 31.6(i)1 | E 009 | All residents were potentially affected by the deficient practice stated in the statement of deficiencies<br>No resident were affected by the deficient practice<br>The U.S. FOIA (b)(6) on 12/26/24 spoke with a representative at the OEM of Salem County. The emergency preparedness plan was sent on 12/26/2024 to the office of the OEM Salem County<br>On 12/23/2024 The U.S. FOIA (b)(6) in serviced the U.S. FOIA (b)(6) [redacted] on the regulation and importance of communicating with the local OEM<br>The administrator will conduct an audit monthly to ensure that compliance is met for 3 months<br>The results of the audits will be reported to the facility monthly QAPI committee meeting for one quarter to determine if sufficient compliance has been met.<br>Based on the results of the audit the QAPI committee will determine continued need for the audit. Compliance date 12/26/2024 | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/05/2024 and | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BIG OAK REHABILITATION AND HEALTHCARE CENTER** | **849 BIG OAK ROAD**<br>**PITTSGROVE, NJ 08318** |

| (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 | Continued From page 2<br>12/06/2024. Big Oak Rehabilitation And Healthcare Center 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 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.<br><br>Big Oak Rehabilitation And Healthcare Center is single story Type V unprotected building that was built in 1967. The facility is divided into 4 smoke zones. The facility has a Natural gas emergency generator. The facility uses well water for both potable water and fire sprinkler system. The sprinkler system is a dry sprinkler system with 2 dry valves and 2 pressurized underground water storage tanks located in an underground enclosure separate from the facility. | K 000 | | |
| K 271 SS=F | Discharge from Exits<br>CFR(s): NFPA 101<br><br>Discharge from Exits<br>Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface.<br>18.2.7, 19.2.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 12/06/24 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to maintain a stable, level walking surface at exit discharge for 1 of 6 exterior exits | K 271 | All residents on the NJ Exec Order 26.4b1 Hallway were potentially affected by the deficient practice stated in the statement of deficiencies<br>No resident were affected by the deficient | 12/26/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BIG OAK REHABILITATION AND HEALTHCARE CENTER** | **849 BIG OAK ROAD**<br>**PITTSGROVE, NJ 08318** |

| (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 271 | Continued From page 3<br>observed in accordance with NFPA 101:2012 Edition, Section 7.7 and 7.1.7. This deficient practice had the potential to affect 78 residents and was evidenced by the following:<br><br>An observation at 10:00 AM revealed that the NJ Exec Order 26.4b1 hall exterior exit's exit discharge path to a public way posed a trip hazard in the path of egress for evacuation. There was a patched hole across the 3 foot wide path that had a 16-inch wide by 1 1/4-inches lip coming up, measured by a standard tape measure.<br><br>In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations.<br><br>A Life Safety Code exit conference was attempted on 12/06/24 but the U.S. FOIA (b)(6) had left for the day and were not available. | K 271 | practice as there was no emergency that required to use that exit<br>On 12/23/24 the U.S. FOIA (b)(6) in serviced the U.S. FOIA (b)(6) on the regulation<br>The deficient practice stated in the SOD (Statement of Deficiencies) was fixed on 12/26/2024 see attached<br>The maintenance director will do weekly audits to the emergency exits for 1 month and then biweekly for 3 months.<br>The results of the audits will be reported by the Maintenance Director to the facility monthly QAPI committee meeting for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit. Compliance date 12/26/2024 | |
| K 321 SS=F | NJAC 8:39-31.2 (e)<br>Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of | K 321 | | 1/7/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BIG OAK REHABILITATION AND HEALTHCARE CENTER** | **849 BIG OAK ROAD**<br>**PITTSGROVE, NJ 08318** |

| (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 321 | Continued From page 4<br>hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interview 11/06/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7, 8.4. This deficient practice had the potential to affect 78 residents and was evidenced by the following:<br><br>An observation at 10:05 AM revealed the door to the NJ Exec C[redacted] wing old tub room used as a storage room with combustible boxes and construction supplies and was not provided with a door that was self-closing or automatic closing. The door also had a louver panel 19-1/2 inches by 11-3/4 inches with slots that would allow the passage of smoke and fire through the door into the exit corridor.<br><br>An observation at 10:25 AM revealed the west wing soiled linen room containing linen bins, a 50 gallon trash receptacle, storage and hand | K 321 | All residents were potentially affected by the deficient practice stated in the statement of deficiencies<br>No resident were affected by the deficient practice<br>On 12/12/24 the deficient practice stated on the SOD (Statement of Deficiencies) was addressed by the following :<br>On 12/15/24 the Old Tube Room on NJ Exec C[redacted] unit was emptied of all combustibles and construction supplies. On 12/16/24 A vendor was called to install a fire door and the maintenance director will install an automatic closure.<br>West wing soiled linen room latch was replaced on 12/6/2024 after the observation with the Life Safety team.<br>On 12/15 the U.S. FOIA (b)(6) in serviced the U.S. FOIA (b)(6) [redacted] on the regulation pertaining to the Hazardous Areas-Enclosures.<br>Weekly audits will be completed by the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **BIG OAK REHABILITATION AND HEALTHCARE CENTER** | **849 BIG OAK ROAD**<br>**PITTSGROVE, NJ 08318** |

| (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 321 | Continued From page 5<br>sanitizer storage did not positive latch when opened to 90 degrees and released. The test was repeated 3 times by the [redacted] with the same results.<br><br>In interviews at the times, the [redacted] and [redacted] confirmed the observations.<br><br>A Life Safety Code exit conference was attempted on 12/06/24 but the[redacted] had left for the day and were not available.<br><br>N.J.A.C 8:39-31.2(e) | K 321 | Administrator or Maintenance director for one month and then every other week for 3 months.<br>The results of the audits will be brought by the Maintenance Director to the QAPI committee to determine if compliance was met. | |
| K 345 SS=F | Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>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.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and interviews on 12/05/24 and 12/06/24 in the presence of the [redacted], it was determined that the facility failed to ensure a sensitivity testing of smoke detectors was conducted every alternate year in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect 78 residents and was evidenced by the following: | K 345 | All residents were potentially affected by the deficient practice stated in the statement of deficiencies<br><br>No resident were affected by the deficient practice<br><br>On 12/20/24 a vendor was called to schedule a sensitivity test<br><br>On 12/20/24 the[redacted]ator in serviced | 1/8/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **BIG OAK REHABILITATION AND HEALTHCARE CENTER** | **849 BIG OAK ROAD**<br>**PITTSGROVE, NJ 08318** |

| (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 |
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| K 345 | Continued From page 6<br>A documentation review on 12/05/24 between 9:00 AM and 3:00 PM, revealed the fire alarm inspection reports provided did not indicate smoke detector sensitivity testing was conducted.<br><br>In an interview on 12/05/24 at 2:35 PM the surveyor asked the U.S. FOIA (b)(6) for the last sensitivity test.<br><br>In an interview on 12/06/24 at 9:00 AM, the U.S. FOI stated the facility changed fire alarm system service vendors and was unable to provide any documentation of the fire alarm sensitivity testing of smoke detectors from the previous vendor.<br><br>In an interview at the time, the U.S. FOIA (b)(6) was informed of the documentation review.<br><br>A Life Safety Code exit conference was attempted on 12/06/24 but the U.S. FOIA (b)(6) and U.S. FOI had left for the day and were not available.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 70, 72 | K 345 | the maintenance director on the regulation The maintenance director will conduct monthly audits on the required testing for the alarm system for 3 months<br><br>The results of the audits will be brought by the Maintenance Director to the QAPI committee to determine if compliance was met. | |
| K 353 SS=F | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>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 available.<br>a) Date sprinkler system last checked<br>_____ | K 353 | | 1/7/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 353 | Continued From page 7<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review, observations and interviews on 12/05/24 and 12/06/24 in the presence of the U.S. FOIA (b)(6) and U.S. FOIA (b)(6), it was determined that the facility failed to ensure that automatic sprinkler systems were inspected, tested, and maintained in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice had the potential to affect 78 residents and was evidenced by the following:<br><br>A documentation review on 12/05/24 between 10:00 AM and 2:35 PM of the fire sprinkler system inspection reports, revealed the facility had 2 dry sprinkler systems that did not have an air leak test performed in the last 3 years as required. The annual report from 5/10/24 stated in the comments section " no record of 3 year gas leakage test." The quarterly reports from 8/7/24 and 11/22/24 stated in the comments section, "corrosion was found on piping in vault located upstream from underground piping and will need to perform air leakage test to determine if pipe integrity has been compromised." No further documentation was provided.<br><br>In an interview at the time, the U.S. FOI confirmed the observations. | K 353 | All residents were potentially affected by the deficient practice stated in the statement of deficiencies<br>No resident were negatively affected by the deficient practice stated on the statement of deficiencies<br>On 12/12/24 a vendor was called to schedule the air leak test. As well as ordered from the vendor the escutcheon plates indicated in the SOD #1, #2, #4,# 7, #8,<br>#3 The maintenance team ordered on 12/19/24 the parts to cover the 7 BX wires in the west wing medication room<br>On 12/15/24 the ceiling was fixed in the activities room #5 see attached<br>#6 on 12/15/24 the space along the sprinkler in the housekeeping office was fixed see attached<br>#10 on 12/15/24 the smoke detector by room 10 was fixed and placed on the ceiling see attached<br>On 12/12/24 The NJ Exec Order 26.4b1 in serviced the U.S. FOIA (b)(6) on the regulations in maintaining the sprinkler system and testing.<br>The maintenance director will do weekly audits for 1 month and biweekly for 2 months. The results of these audits will be | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| K 353 | Continued From page 8<br>Observations on 12/06/24 between 9:00 AM and 12:15 PM revealed the following:<br><br>1. The sprinkler head in resident room [redacted] bathroom ceiling had an oversized escutcheon plate not compatible with the sprinkler, leaving a 1-3/4 inch by 3/4-inch space on the side of the sprinkler pipe.<br><br>2. In the [redacted] unit biohazard closet, 1 of 2 sprinklers did not have an escutcheon plate. Additionally, there was a 2-inch by 12-inch hole through the ceiling in front of the HVAC duct by the sprinkler.<br><br>3. In the west wing medication room, there were 7 BX wires coming through a 2-1/2 inch by 5-inch penetration in the wall going up into a 3-inch by 1-1/2 inch penetration in the ceiling.<br><br>4. In the corridor ceiling outside room [redacted], there was an escutcheon plate attached to the drop ceiling tile and not the sprinkler. The sprinkler was hitting one side of the escutcheon and leaving a 1-1/4 inch by 3/4-inch space on the other side.<br><br>5. In the activities room drop ceiling, 1 of the 2 light fixtures had a 18-inch by 2-inch hole on one side and a 3-inch by 7-inch hole on the other side through the drop ceiling.<br><br>6. In the housekeeping office, there was a space along one side of the sprinkler head that went through the ceiling.<br><br>7. In the kitchen ceiling by the dishwasher, the sprinkler head had no escutcheon. | K 353 | brought to the facility QAPI committee to determine if compliance was met. | |

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|---|---|---|---|---|
| K 353 | Continued From page 9<br>8. The front reception desk closet, the sprinkler had no escutcheon.<br><br>9. The basement spare sprinkler head box mounted on the wall by the exterior exit had no spare sprinkler heads in it.<br><br>10. The smoke detector in the corridor ceiling by room [redacted] was hanging down 1-1/2 inches on one side leaving a 4-inch by 4-inch space open through the drop ceiling.<br><br>In an interview at the time, the U.S. FOIA (b)(6) [redacted] confirmed the observations.<br><br>A Life Safety Code exit conference was attempted on 12/06/24 but the U.S. FOIA (b)(6) [redacted] had left for the day and were not available.<br><br>N.J.A.C 8:39-31.2 (e)<br>NFPA 25 | K 353 | | |
| K 355<br>SS=F | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews on 12/06/24 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that Class K portable fire extinguishers were provided with the required instructional placard and that the | K 355 | All residents were potentially affected by the deficient practice stated in the statement of deficiencies<br>No resident were negatively affected by the deficient practice stated on the statement of deficiencies | 1/7/25 |

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|---|---|---|---|---|
| K 355 | Continued From page 10<br>monthly inspections were conducted on the kitchen wet chemical suppression cylinder in accordance with NFPA 101: 2012 Edition, Sections 9.7.4, NFPA 10: 2010 Edition, Sections 5.5.5.3, A 5.5.5.3 and NFPA 17A: 2009 Edition, Sections 7.2 and 7.3.3. This deficient practice had the potential to affect 78 residents and was evidenced by the following:<br><br>An observation at 11:03 AM of the kitchen wet chemical suppression system cylinder inspection tag, revealed the monthly inspection rows on the back of the tag were blank.<br><br>In an interview at the time, the [redacted] confirmed the observation.<br><br>An observation at 11:17 AM revealed the Class K fire extinguisher in the kitchen area was not provided with an instruction placard that stated that the fire protection system shall be actuated prior to using the portable fire extinguisher.<br><br>In an interview at the time, the [redacted] confirmed the observation.<br><br>A Life Safety Code exit conference was attempted on 12/06/24 but the [redacted] had left for the day and were not available.<br><br>N.J.A.C 8:39-31:2(e)<br>NFPA 10, 96, 17A | K 355 | On 12/12/24 the vendor called for the kitchen wet chemical suppression system cylinder inspection<br>On 12/12/24 the class K fire extinguisher sign was put up and the team in serviced see attached<br><br>On 12/12/24 The [redacted] in serviced the [redacted] on the regulations in maintaining the sprinkler system and testing.<br>The maintenance director will do weekly audits for 1 month and biweekly for 2 months. The results of these audits will be brought to the facility QAPI committee to determine if compliance was met. | |
| K 363<br>SS=E | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or | K 363 | | 12/24/24 |

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|---|---|---|---|
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|---|---|---|---|---|
| K 363 | Continued From page 11<br>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 frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews on 12/06/24 in the presence of the U.S. FOIA (b)(6) [redacted] it was | K 363 | Residents in rooms NJ Exec Order 26.4b1 were potentially affected by the deficient practice stated in the statement of | |

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| K 363 | Continued From page 12<br>determined that the facility failed to ensure that doors in the corridor could resist the passage of smoke and had positive latching hardware for 4 of 11 doors observed in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3 and 19.3.6.3.10. This deficient practice had the potential to affect 8 of 78 residents and was evidenced by the following:<br><br>Observations between 9:21 AM and 12:15 PM revealed the following:<br><br>1. The door to resident room [redacted] did not shut properly because it rubbed on the floor, preventing it from closing without force. Additionally, the door did not positively latch when closed. Test was repeated 2 times by the U.S. FOIA (b)(6) r with the same results.<br><br>2. The door to resident room [redacted] did not positive latch when shut because the back edge was hitting door frame when closed. The test was repeated by the U.S. FOIA (b)(6) with the same results.<br><br>3. The door to resident room [redacted] did not positively latch because it would not pull closed. The test was repeated by the U.S. FOIA (b)(6) with the same results.<br><br>4. The door to resident room [redacted] did not positively latch because it would not pull closed. The test was repeated by the U.S. FOIA (b)(6) with the same results.<br><br>In an interview at the time, the [redacted] stated that the paint was built up on the back edge of the doors and was hitting the door frames which prevented the doors from closing. | K 363 | deficiencies<br>No residents were negatively affected by the deficient practice stated on the statement of deficiencies<br>On 12/15/24 all 4 doors were fixed they all shut without force and positive latch see attached<br>On 12/12/24 The U.S. FOIA (b)(6) in serviced the U.S. FOIA (b)(6) on the regulations regarding fire doors.<br>The maintenance director will do weekly audits for 1 month and biweekly for 2 months. The results of these audits will be brought to the QAPI committee to determine if compliance was met. | |

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|---|---|---|---|---|
| K 363 | Continued From page 13<br><br>In interviews at the times, the U.S. FOIA (b)(6) [redacted] confirmed the observations.<br><br>A Life Safety Code exit conference was attempted on 12/06/24 but the U.S. FOIA (b)(6) [redacted] had left for the day and were not available.<br><br>N.J.A.C 8:39-31.2 (e)<br>NFPA 101 | K 363 | | |
| K 914 SS=F | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, documentation review | K 914 | All residents were potentially affected by | 1/7/25 |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 914 | Continued From page 14<br>and interview on 12/05/24 and 12/06/24 in the presence of the U.S. FOIA (b)(6) and U.S. FOIA (b)(6), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms that had non-hospital grade outlets annually for grounding, polarity, blade tension and physical integrity in accordance with NFPA 99: 2012 Edition, Section 6.3, and 6.3.3.2, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect 78 residents and was evidenced by the following:<br><br>Observations and interview on 12/06/24 confirmed that the facility had non-hospital grade outlets installed in resident rooms.<br><br>A documentation review on 12/05/24 between 09:00 AM and 3:00 PM revealed there were daily room inspection check lists which did not include checking outlets. There was no documentation the required resident bed side electrical outlets inspections and tests for: physical integrity, grounding, polarity and blade tension were performed in the last 12 months.<br><br>In an interview at the time, the NJ Exec Order 26.4b [redacted] confirmed the documentation review.<br><br>A Life Safety Code exit conference was attempted on 12/06/24 but the U.S. FOIA (b)(6) [redacted] had left for the day and were not available.<br><br>NJAC 8:39-31.2(e)<br>NFPA 99 | K 914 | the deficient practice stated in the statement of deficiencies<br>No resident were negatively affected by the deficient practice stated on the statement of deficiencies<br>On 12/12/24 a vendor was called to schedule a facility wide electrical test<br>Please see attached electrical inspection which includes outlets indicated on the Statement of Deficiencies.<br>On 12/12/24 The U.S. FOIA (b)(6) in serviced the U.S. FOIA (b)(6) [redacted] on the regulations regarding electrical systems maintenance<br>The maintenance director will do weekly audits for 1 month and biweekly for 2 months. The results of these audits will be brought to the QAPI committee to determine if compliance was met. | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101 | K 918 | | 12/24/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| K 918 | Continued From page 15<br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and documentation review on 12/05/24 and 12/06/24 in the presence of the U.S. FOIA (b)(6), it | K 918 | All residents were potentially affected by the deficient practice stated in the statement of deficiencies | |

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|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| K 918 | Continued From page 16<br>was determined that the facility failed to provide a letter of reliability from the natural gas supplier for their natural gas generator, failed to conduct a 36 month 4 hour load test, and failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame in accordance with NFPA 99: 2012 Edition and NFPA 110: 2010 Edition. These deficient practices had the potential to affect 78 residents and was evidenced by the following:<br><br>A record review between 9:00 AM and 3:00 PM revealed the following:<br><br>1. There was no letter of reliability from the natural gas supply company to provide natural gas to the facility for their emergency power generator.<br><br>2. On the monthly full load test log sheets for the past 12 months, there were no transfer times recorded for the transfer of power from primary utility power to secondary generator power to document power was transferred within the 10 second timeframe as required.<br><br>The log dates for the weekly and monthly generator tests did not have the year in the date row. The monthly log dates were as follows: 11/08, 10/11, 9/20, 8/30, 7/26, 6/28, 5/31, 4/26 3/28, 2/23, 1/26, and 12/29.<br><br>3. There was no documentation of a 4 hour full load test performed in the last 36 months.<br><br>The U.S. FOIA (b)(6) were made aware of the missing documentation on 12/05/24 at 2:35 PM. | K 918 | No resident were negatively affected by the deficient practice stated on the statement of deficiencies<br>On 12/20/24 the maintenance director reached out to the vendor for the letter of reliability<br>#2 See attached Monthly (Full Load) log sheets with transfer times<br>#3 A 4 hour full load test was completed on 12/24/2024<br>On 12/20/24 The U.S. FOIA (b)(6) in serviced the U.S. FOIA (b)(6) on the regulations regarding electrical systems maintenance<br>The maintenance director will do weekly audits for 1 month and biweekly for 2 months. The results of these audits will be brought to the QAPI committee to determine if compliance was met. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BIG OAK REHABILITATION AND HEALTHCARE CENTER** | **849 BIG OAK ROAD**<br>**PITTSGROVE, NJ 08318** |

| (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 918 | Continued From page 17<br>In an interview on 12/06/24 at 9:00 AM, the U.S. FOIA (b)(6) confirmed they did not have a letter of reliability from the natural gas supplier or any other documents that were requested on 12/05/24.<br><br>A Life Safety Code exit conference was attempted on 12/06/24 but the NJ Exec Order 26.4b1 had left for the day and were not available.<br><br>NJAC 8:39-31.2(e), 31.2(g)<br>NFPA 99, 110 | K 918 | | |
| K 921 SS=F | Electrical Equipment - Testing and Maintenanc<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Testing and Maintenance Requirements<br>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 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 | K 921 | | 1/7/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

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|---|---|---|---|---|
| K 921 | Continued From page 18<br>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.<br>10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and interview on 12/05/24 and 12/06/24 in the presence of the U.S. FOIA (b)(6), it was determined that the facility did not provide policies and procedures for Patient Care Related Electrical Equipment (PCREE), and conduct maintenance of electrical equipment and maintain a record log of all required testing, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. The deficient practice had the potential to affect 78 residents and was evidenced by the following:<br><br>A documentation review on 12/05/24 between 9:00 AM and 3:00 PM revealed there was no documentation of PCREE testing, inspection and maintenance. In an interview at 3:00 PM, the surveyor asked the U.S. FOIA (b)(6) for any PCREE documents.<br><br>In an interview on 12/06/24 at 9:00 AM, the U.S. FOI [redacted] stated that there were no inspection reports for patient care related electrical equipment for the facility at this time.<br><br>A Life Safety Code exit conference was attempted on 12/06/24 but the U.S. FOIA (b)(6) [redacted] had left for the day and were not available. | K 921 | All residents were potentially affected by the deficient practice stated in the statement of deficiencies<br>No resident were negatively affected by the deficient practice stated on the statement of deficiencies<br>On 12/20/24 a vendor was called and the inspection was scheduled for facility wide electrical equipment testing<br>Please see attached Electrical Equipment log from the vendor on 1/7/25<br>On 12/20/24 The U.S. FOIA (b)(6) in serviced the U.S. FOIA (b)(6) on the regulations regarding electrical equipment testing and Maintenance<br>The maintenance director will do weekly audits for 1 month and biweekly for 2 months. The results of these audits will be brought to the QAPI committee to determine if compliance was met. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315014 | A. BUILDING **01**<br>B. WING _____ | **12/11/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **BIG OAK REHABILITATION AND HEALTHCARE CENTER** | **849 BIG OAK ROAD**<br>**PITTSGROVE, NJ 08318** |

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|---|---|---|---|---|
| K 921 | Continued From page 19<br>NJAC 8:39-31.2(e)<br>NFPA 99 | K 921 | | |

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 |
|---|---|---|
| 315014 Y1 | A. Building 01 - MAIN BUILDING 01<br>B. Wing Y2 | 1/15/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIG OAK REHABILITATION AND HEALTHCARE CENTER | 849 BIG OAK ROAD<br>PITTSGROVE, NJ 08318 |

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 K0271 | 12/26/2024 | LSC K0321 | 01/07/2025 | LSC K0345 | 01/08/2025 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0353 | 01/07/2025 | LSC K0355 | 01/07/2025 | LSC K0363 | 12/24/2024 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0914 | 01/07/2025 | LSC K0918 | 12/24/2024 | LSC K0921 | 01/07/2025 |
| 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? |
|---|---|
| 12/11/2024 | ☐ YES ☐ NO |