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 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLEVIEW HEALTH & REHABILITATION	**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 000	INITIAL COMMENTS COMPLAINT#: NJ165382 CENSUS: 70 SAMPLE SIZE: 10 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		9/7/23

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

Electronically Signed | 08/28/2023

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 755	Continued From page 1 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ165382 Based on observations, interviews, review of medical record (MR) and other pertinent facility documentation on 7/28/23, it was determined that the facility failed to a.) maintain professional standards of practice by not ensuring the medication nurse consistently followed the cautionary instruction for a medication administered. The deficient practice was identified for 1 of 7 residents (Resident's #5) by 1 of 3 nurses observed during medication pass and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 755	Upon being made aware of the concerns on 7/28/23 the facility corrected all of the issues to ensure proper medication administration [redacted]. Resident #5 identified in the SOD was immediately monitored to ensure no adverse reactions and a competency was completed with nurse LPN#3 on inhaler administration. Residents of the facility have had the potential to be affected by the deficient practice noted in the SOD. An audit was completed, and no residents were found to have been negatively affected. On 7/28/2023 The entire nursing department had an immediate extensive in-service provided by the Director of Nursing related to inhalation administration. Hired a new Pharmacy consultant. The DON/designee will conduct bi-weekly audits, on inhaler administration to ensure proper administration and best outcomes. The results of the audit will be reported to the facility QAPI Committee for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee	

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F 755	Continued From page 2 On 7/28/23 at 8:58 AM, the surveyor observed the Licensed Practical Nurse (LPN #3) prepare five medications for Resident #5. LPN #3 administered the five medications to Resident #5, exited the room, and signed the medications as administered on the Medication Administration Record (MAR). At 9:15 AM, the surveyor observed LPN #3 prepare an additional medication for Resident #5. The surveyor observed that the resident's 7/2023 MAR reflected an order for [redacted]. The surveyor further observed that the [redacted] medication box contained a cautionary instruction (a method or procedure intended to prevent or avoid adverse outcomes with medication administration) to "RINSE MOUTH THOROUGHLY AFTER EACH USE." The surveyor observed LPN #3 administer the medications to the resident. During administration of the resident's medication, LPN #3 held the [redacted] to Resident #5's mouth and instructed to resident to inhale deeply. LPN#3 then exited the resident's room. The surveyor did not observe LPN #3 offer or instruct Resident #5 to [redacted] thoroughly after the administration of the [redacted]. After assisting another resident, the surveyor observed LPN #3 begin to push the medication cart down the hallway away from Resident #5's room. At which time, the surveyor questioned the nursing practice when administering [redacted]. LPN #3 stated that she would normally have the resident [redacted]. LPN #3 added that Resident #5 had some [redacted] and that she did not offer the resident	F 755	will determine continued need for the audit. Completion date 9/7/2023	

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F 755	Continued From page 3 to [redacted] out because the resident "would not spit it out but would just drink it." LPN #3 added that [redacted] can cause [redacted] ([redacted]) and that it was important to [redacted] after administration. According to the Admission record, Resident #5 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]. Review of the "Order Summary Report" for Resident #5 for active orders as of [redacted] revealed a [redacted] physician order (order), with a start date of [redacted] for [redacted] and to administer [redacted] daily related to [redacted]. The order did not include the cautionary to [redacted]. Review of the Resident #5's [redacted] MAR revealed the corresponding [redacted] order, with the start date of [redacted], for [redacted] to administer [redacted] daily related to [redacted]. The MAR did not include the cautionary to [redacted]. During an interview on 7/28/23 at 11:03 AM, the LPN/Infection Preventionist (LPN/IP) stated that nurses should take a cup of water into the resident's room when administering a [redacted]. The LPN/IP added that the nurse should explain and/or demonstrate the [redacted]" process to the resident. The nurse would then have the resident [redacted]	F 755		

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F 755	Continued From page 4 after administering a [redacted] to prevent the resident from [redacted]. The LPN/IP stated that LPN #3 should have at least offered the resident water because confused residents can develop [redacted] During an interview on 7/28/23 at 12:04, the Director of Nursing (DON) stated the administering nurse should have the resident [redacted]" after the administration of a [redacted] to prevent [redacted] or [redacted] in their mouth. The DON added that the physician should be contacted for another option if a resident is unable to [redacted] Review of the facility's "Administering Medications through Metered Dose Inhaler" did not address medication cautionary instructions.	F 755		
F 880 SS=D	NJAC 8:39-11.2(b) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		9/9/23

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F 880	Continued From page 5 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 6 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ165382 Based on observations, interviews, review of medical record and other pertinent facility documentation on 7/28/23, it was determined that the facility failed to: a.) maintain infection control practices when administering insulin. The facility also failed to follow its policy titled "Insulin Administration." The deficient practice was identified for 1 of 7 residents (Resident's #4) by 1 of 3 nurses observed during medication pass and was evidenced by the following: On 7/28/23 at 8:25 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) prepare three medications for Resident #4. The medications included [redacted] a [redacted], and a [redacted]. LPN #1 entered the resident's room to administer the	F 880	Upon being made aware of the concerns on 7/28/23 the facility corrected all of the issues to ensure there are no infection control issues. Resident #4 identified in the SOD was immediately monitored to ensure no adverse reactions and a competency was completed with nurse LPN#1 on [redacted] administration. All residents have the potential to be affected. An audit was completed, and no residents were found to have been negatively affected. On 7/28/2023 The entire nursing department had an immediate extensive in-service provided by the Director of Nursing related to Infection Control and medication administration. Hired a new Infection preventionist. The Infection Preventionist/designee will conduct weekly audits, on infection control to ensure there are no infection control breaches. The results of the audit will be reported to the facility QAPI Committee	

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F 880	Continued From page 7 three medications to Resident #4. The surveyor observed LPN #1 place the [redacted] on the resident's overbed table alongside the resident's personal belongings while she administered the [redacted]. LPN #1 did not clean and sanitize the overbed table prior to placing the [redacted]. LPN #1 then picked up the [redacted] and [redacted] to Resident #4's [redacted] LPN#1 did not cleanse the [redacted] with an alcohol wipe prior to [redacted] into Resident #4's [redacted]. LPN #1 then exited the room and began to walk to her medication cart. At which time, the surveyor questioned the nursing practice when administering [redacted] LPN #1 said "Oops, sorry!" and further stated that she was supposed to cleanse the [redacted] prior to administering the [redacted]. According to the Admission record, Resident #4 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] Review of the Resident #4's "Order Summary Report" for active orders as of [redacted] revealed a [redacted] physician order (order) for [redacted] and to [redacted]. Review of the Resident #4's 7/2023 MAR revealed the corresponding [redacted] order for [redacted] to [redacted] three times a day for [redacted] with the administration times of 7:30 AM, 11:00 AM, and 4:30 PM.	F 880	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 and further interventions. Completion date 9/9/23	

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F 880	Continued From page 8 During an interview on 7/28/23 at 11:03 AM, the LPN/Infection Preventionist (LPN/IP) stated that she expected nurses to maintain safety and infection control practices when administering medications to the residents. The LPN/IP further stated that nurses should not place a resident's [redacted] on the overbed table and that the [redacted] would then be considered "dirty." The LPN/IP explained the process of administering injections. The nurse would cleanse the insertion site with an alcohol wipe, allow the site to air dry, and then administer the injection as ordered. The LPN/IP added that the nurse should maintain the [redacted] in their possession and not place it on the overbed table. During an interview on 7/28/23 at 12:04, the Director of Nursing (DON) stated the nurse should not place the resident's [redacted] on the overbed table. The DON further stated that the injection site needed to be cleansed with an alcohol pad prior to inserting the needle for infection control purposes. The DON added that the resident's skin may have [redacted] and that failing to cleanse the insertion site may introduce [redacted] into the resident's body. Review of the facility's undated "Insulin Administration" policy, instructed under the "Steps in the Procedure (Insulin Injections via Syringe)" section to "17. Clean the injection site with an alcohol wipe and allow to air dry." Review of the facility's undated "Administering Medications" policy, revealed under the "Policy Interpretation and Implementation" section that "25. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for	F 880		

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F 880	Continued From page 9 the administration of medications, as applicable." NJAC 8:39-11.2(b) NJAC 8:39-19.4	F 880		

New Jersey Department of Health

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	061704	A. BUILDING: _____ B. WING _____	C 07/28/2023

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S 000	Initial Comments COMPLAINT#: NJ00165382 CENSUS: 70 SAMPLE SIZE: 10 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ165382 Based on facility document review on 07/27/23 and 07/28/23, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 15 of 28 day shifts. This deficient practice was evidenced by the following:	S 560	All residents have the potential to be affected by the deficient practice stated on the SOD A staffing and Recruitment/Retention committee including Director of Nursing, HR Director, Staffing Coordinator, and Administrator/designees has been convened on 8/21/2023 and will meet four times a week to review retention efforts, open positions, recruitment tactics, and changes to improve outcomes staffing for	9/9/23

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

Electronically Signed — 08/28/23

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S 560	Continued From page 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: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The survey team requested staffing for the weeks of 07/09/2023 to 07/15/2023 and 07/16/2023 to 07/22/2023. The facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -07/09/23 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs. -07/10/23 had 5 CNAs for 66 residents on the day shift, required at least 8 CNAs. -07/11/23 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs.	S 560	upcoming week. The facility has contracts in place with multiple staffing agencies as an effort to provide additional staff when needed. 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, Implementation of Hosted Time, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Rate adjustments, Benefit adjustments and Contract staff utilization. The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for two months and then quarterly. The results of Resident Council minutes as well as recruitment data will be reviewed by the Administrator or designee at the quarterly QAPI meeting.	

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S 560	Continued From page 2 -07/12/23 had 6 CNAs for 66 residents on the day shift, required at least 8 CNAs. -07/13/23 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs. -07/14/23 had 7 CNAs for 67 residents on the day shift, required at least 8 CNAs. -07/16/23 had 7 CNAs for 67 residents on the day shift, required at least 8 CNAs. -07/17/23 had 8 CNAs for 70 residents on the day shift, required at least 9 CNAs. -07/18/23 had 7 CNAs for 68 residents on the day shift, required at least 8 CNAs. -07/20/23 had 7 CNAs for 68 residents on the day shift, required at least 8 CNAs. -07/22/23 had 7 CNAs for 68 residents on the day shift, required at least 8 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061704 Y1	A. Building B. Wing Y2	9/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLEVIEW HEALTH & REHABILITATION	849 BIG OAK ROAD 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	09/09/2023	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/28/2023	☐ 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 B. Wing Y2	9/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLEVIEW HEALTH & REHABILITATION	849 BIG OAK ROAD 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 F0755	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	09/09/2023	LSC	09/09/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/28/2023	☐ YES ☐ NO