

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Big Oak Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 849 Big Oak Road Pittsgrove, NJ 08318	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Complaint #2793788Based on observation and interview it was determined that the facility had insufficient staffing in the kitchen to carry out the duties of the food service operations competently. This deficient practice was evidenced by the following: Cross-reference: F803On 3/23/26 at 10:30 AM, during a Resident Council Meeting with the surveyor, 5 of 6 alert and oriented residents in attendance (#5, #12, #37, #67, and #73) stated that the facility did not have a cook for one day the week prior and they were served cold food for all three meals. The residents stated the facility brought around a cart and handed out cereal and milk for breakfast. On 3/23/25 at 10:44 AM, the surveyor observed the Food Service Director (FSD) making lunch. When the surveyor asked if there was a cook, the FSD stated that there was no cook today, so he was covering all the meals. On 3/23/26 at 12:55 PM, the surveyor interviewed a Dietary Aide (DA) that confirmed that she was aware of a day the past week when there was no cook. The DA stated that the cook called out sick and the FSD was also ill. The DA stated that the Registered Dietician (RD) was notified, and the DA was advised to use what was available in the kitchen that did not need to be cooked. The DA added that for breakfast they served cold cereal, milk, and juice, the lunch meal was cold cut sandwiches and chips, and the dinner was cold cut lunchmeat wraps (ham). Nothing was cooked and no vegetables were offered since they required cooking. On 3/24/26 at 10:23 AM, during an interview with the FSD and the RD, it was confirmed that on 3/18/26 both the FSD and the scheduled cook were sick and there was no cook on duty. The RD confirmed that she was notified, and they managed with the food that was available that did not require cooking. When asked if the meals served met the daily nutritional needs requirement, the RD admitted that it did not. A review of the kitchen schedule provided for the month of March revealed that the FSD covered the cooking most days and that there was only one cook on the schedule for the month. The FSD stated that the one cook was scheduled five days a week and was off on Mondays and Thursdays. The cook came in at 11:30 AM and worked until closing. The FSD covered all breakfast meals during the week and the weekends, as well as all meals Mondays and Thursdays. When the surveyor asked why there were no back up cooks, the FSD stated that previously they did have three cooks on the schedule to rotate days and meals, but two of the cooks had quit. When the surveyor asked what constituted a full staff, the FSD responded ideally, three full time cooks and one part time, which would allow for all shifts to be shared for meals (early morning and evenings till closing) as well as rotation of the weekends. On 3/25/26 at 12:37 PM, the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Registered Nurse (RRN), were made aware of the concerns regarding the staffing in the kitchen. On 3/26/26 at 9:46 AM, during a meeting with the survey team, the LNHA, the DON, and the RRN, acknowledged the need for more cooks. A review of the facility's Dietary Emergency Staffing policy with a review date of January 2026, included, The facility shall ensure the provision of safe, sanitary, and nutritionally adequate meals to all residents in accordance with physician orders and resident care plans, even in the absence of a scheduled cook, in compliance with federal regulations (42 CFR 483.60). Under Responsibility, the Administrator is responsible for oversight and regulatory compliance. NJAC 8:39-17.3		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 315014 If continuation sheet Page 1 of 5

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris and failed to have a cover over the opening of 3 of 3 garbage containers/dumpsters. This deficient practice was evidenced by the following: On 3/20/26 at approximately 10:00 AM, the surveyor, accompanied by the Food Service Director (FSD), observed three (3) yard dumpsters that were designated for garbage in the facility parking lot. 3 of 3 dumpsters designated for garbage had the contents of bagged trash exposed due to the dumpster lids not being closed. Each dumpster had two (2) plastic lids to cover the dumpster opening. On interview the FSD told the surveyor that the garbage area was a shared responsibility between the kitchen staff and environmental staff, and they were responsible for the maintenance of the area. In addition to the exposed contents of the dumpsters, the area surrounding the garbage dumpsters was observed to have garbage on the ground. The garbage included plastic cups, disposable gloves, plastic bags, paper products and other unidentified debris. On 3/25/26 at 12:37 PM, the Licensed Nursing Home Administrator (LNHA) stated in the presence of the Director of Nursing (DON), the Regional Registered Nurse DON and the survey team, that he usually made sure the dumpster area was free of debris and covered since they were cited before. A reviewed of a facility policy titled, Food-Related Garbage and Refuse Disposal, dated September 2025, revealed the following: Food-related garbage and refuse are disposed of in accordance with current state laws. All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. NJAC 8:39-19.3(c)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview, record review, and a review of pertinent facility documents, it was determined that the facility failed to consistently implement their Antibiotic Stewardship Program (ASP), a program designed to improve clinical outcomes and reduce harm by promoting and monitoring the appropriate use of antibiotics. This deficiency was identified for 5 of 5 residents (Resident #5, #18, #19, #39, and #61) reviewed for antibiotic use and was evidenced by the following: On 3/23/26 at 9:15 AM, the Infection Preventionist (IP) provided the facility's antibiotic stewardship binders for the years 2025 and 2026. A review of the facility's Antibiotic Stewardship line list for February 2026 revealed the following residents were prescribed antibiotics while at the facility: 1. Resident #5 was prescribed an antibiotic on 2/7/26 for 7 days for cellulitis [a skin or soft tissue infection (SSTI)]. The line list further indicated that an infection assessment tool was completed, but the criteria for antibiotic use was not met. 2. Resident #18 was prescribed an antibiotic on 2/4/26 for 5 days for an upper respiratory infection (URI). The line list further indicated that an infection assessment tool was completed, but the criteria for antibiotic use was not met. 3. Resident #19 was prescribed an antibiotic on 2/14/26 for 7 days for a urinary tract infection (UTI). The line list further indicated that an infection assessment tool was completed, but the criteria for antibiotic use was not met. 4. Resident #39 was prescribed an antibiotic on 2/21/26 for 7 days for a UTI. The line list further indicated that an infection assessment tool was completed, but the criteria for antibiotic use was not met. 5. Resident #61 was prescribed an antibiotic on 2/28/26 for 10 days for a UTI. The line list further indicated that an infection assessment tool was completed, but the criteria for antibiotic use was not met. A review of the corresponding McGeer Criteria for Infection Surveillance Checklist forms for the above five residents revealed the following: 1. Resident # 5's McGeer Criteria indicated that the resident had not met the described SSTI criteria for antibiotic use. 2. Resident # 18's McGeer Criteria indicated that the resident had not met the described URI criteria for antibiotic use. 3. Resident # 19's McGeer Criteria indicated that the resident had not met the described UTI criteria for antibiotic use. 4. Resident # 39's McGeer Criteria indicated that the resident had not met the described UTI criteria for antibiotic use. 5. Resident # 61's McGeer Criteria indicated that the resident had not met the described UTI criteria for antibiotic use. On 3/24/26 at 11:15 AM, the surveyor interviewed the IP who stated that the McGeer surveillance tool was used for all patients who were prescribed antibiotics at the facility. The IP stated that when the McGeer Criteria had not been met, she would communicate with prescribing providers and also discuss in the monthly QAPI meetings. The IP stated that there was one provider (Provider #1) who prescribed antibiotics despite McGeer criteria not being met and that the IP had to educate Provider #1. A review of the in-service sign-in sheet, dated 3/9/26, revealed the following topics of discussion: McGeer criteria; antibiotic usage and stewardship; MD review. There was only the name of Provider #1 written on the sign-in sheet with a signature next to it. Further review of the antibiotic stewardship reports included infection logs between March of 2025 and March of 2026 which included 36 incidents of McGeer criteria which were not met and included the names of prescribing providers in such incidents. There were 5 total providers included in these infection logs who had prescribed antibiotics despite not meeting McGeer criteria. On 3/25/26 at 10:00 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that she performed monthly reviews of prescribed antibiotics. When asked if the CP would provide feedback on antibiotic use to the prescribing practitioner, the CP stated If there is a progress note in the chart describing why a provider feels a patient should be receiving an antibiotic, I do not provide feedback as prescribing is outside of my scope of practice. If there is nothing to support that [antibiotic use] I will put that in there. On 3/25/26 at 10:20 AM, the surveyor interviewed the Medical Director (MD) who stated he had been in that role since November 2025. The MD stated that they reviewed infections along with the DON to see if antibiotics were being used appropriately at the facility. When asked if facility staff provided feedback on antibiotic use to prescribing providers, the (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MD stated that if a resident did not meet the McGeer criteria for antibiotic use, the facility should notify the provider. The MD further stated that the provider should then review the clinical findings and either document the rationale for antibiotic use or discontinue the antibiotic. The Medical Director then verified that Provider #1 had been brought to his attention by the IP, and that he spoke with Provider #1 to discuss the prescribing of antibiotics in February 2026. On 3/25/26 at 10:51 AM, the surveyor interviewed the Director of Nursing (DON) who stated she had been in that role since January of 2026. The DON stated that she audited when antibiotics were ordered to see if clinical findings supported the use of antibiotics. When asked if she would have provided feedback on antibiotic use to a prescribing practitioner, the DON stated, yes, I have a conversation with them to see when we order antibiotics or a urine culture that the resident has met criteria. When asked whether antibiotics should have been prescribed when criteria had not been met, the DON stated that the provider should discontinue the order or documented the rationale for the use of antibiotics. At that time, the surveyor informed the DON of the residents who were prescribed antibiotics without meeting McGeer Criteria and the DON stated that Provider #1 had been identified by the IP as prescribing antibiotics when the resident had not met McGeer Criteria. When asked to elaborate on this, the DON stated, the IP noticed that a lot of residents were getting orders for a urinalysis (urine test for infection) who did not meet criteria for a urinalysis to be completed. Education was provided to [Provider #1] about making sure that symptoms justified the ordering of a urinalysis which would have justified the use of antibiotics. A review of the facility's antibiotic stewardship policy, last revised January 2026, included the following: Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. 1. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. 2. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. 3. Training and education will include emphasis on the relationship between antibiotic use and: gastrointestinal disorders; opportunistic infections (e.g., c. difficile, candida albicans, etc.); medication interactions; and the evolution of drug-resistant pathogens. A review of the facility's Review and Surveillance of antibiotic use and outcomes policy, last revised January 2026, which included the following: Antibiotic usage and outcome data will be collected and documented using a facility approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. 1. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist (IP), or designee. 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. Therapy may require further review and possible changes if: the organism is not susceptible to antibiotic chosen; the organism is susceptible to narrower spectrum antibiotic; therapy was ordered for prolonged surgical prophylaxis; or therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. NJAC 8:39-19.4(d)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and review of facility menus, it was determined that the facility failed to ensure that staff were following the menu. This deficient practice was evidenced by the following: Cross-reference F802 On 3/23/26 at 10:30 AM, during a Resident Council Meeting with the surveyor, 5 of 6 alert and oriented residents (Resident #5, #12, #37, #67, and #73) stated that there was no cook one day the week prior and they were served cold food all three meals. The residents stated the facility brought around a cart and handed out cereal and milk for breakfast. On 3/23/26 at 12:55 PM, the surveyor interviewed a Dietary Aide (DA) that confirmed that she was aware of a day the past week when there was no cook. The DA stated that the cook called out sick and the FSD was also ill. The DA stated that the Registered Dietician (RD) was notified, and the DA was advised to use what was available in the kitchen that did not need to be cooked. The DA added that for breakfast they served cold cereal, milk, and juice, the lunch meal was cold cut sandwiches and chips, and dinner was cold cut lunchmeat wraps (ham). Nothing was cooked and no vegetables were offered since they would require cooking. The surveyor reviewed the facility's 4-week cycle menu titled, Big Oak Rehab & Care Center Menu 2025-2026, week 4. The menu noted on Wednesday 3/18/26 revealed the breakfast menu to be served included orange juice, oatmeal, ham egg cheese breakfast sandwich, 2% milk, and hot beverage of choice. The lunch menu to be served included black bean soup, glazed pineapple ham, mashed potatoes, asparagus, cheesecake 2% milk and hot beverage of choice. The dinner menu to be served included cheeseburger, tater tots, green peas, chocolate ice cream, 2% milk and hot beverage of choice. On 3/24/26 at 10:23 AM, during an interview with the FSD and the RD, it was confirmed that on 3/18/26 both the FSD and the scheduled cook were sick and there was no cook on duty. The RD confirmed that she was notified, and they managed with the food that was available that did not require cooking. The menu was not followed. When asked if the meals served met the daily nutritional needs requirement, the RD admitted that they did not. On review of the facility's Dietary Emergency Staffing policy with a review date of January 2026, included, The facility shall ensure the provision of safe, sanitary, and nutritionally adequate meals to all residents in accordance with physician orders and resident care plans, even in the absence of a scheduled cook, in compliance with federal regulations (42 CFR 483.60). NJAC 8:39 -17.4(a)(3)		