STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jersey Shore Post Acute Rehabilitation and Nursing	101 Walnut Street Neptune, NJ 07753

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 33106 Based on observation, interview, and record review, it was determined that the facility failed to maintain a individualized comprehensive care plan (ICCP) that included interventions that were specific to a resident identified as having a diabetic ulcer. This deficient practice was identified for 1 of 18 residents reviewed (Residents #46), and was evidenced by the following: A review of the Admission Record face sheet (admission summary) indicated that Resident #46 was admitted to the facility with diagnoses which included but was not limited to; diabetes mellitus (DM), chronic osteomyelitis (bone infection), and peripheral vascular disease (PVD). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 1/7/25, reflected that Resident #46 was cognitively intact and required supervision with activities of daily living (ADLs). The MDS also indicated that the resident had a diabetic foot ulcer. On 2/27/25 at 10:47 AM, during tour, the surveyor observed Resident #46 in the facility gym wearing bilateral white stockings on both lower extremities. The resident was alert and oriented and had no complaints. On 3/3/25 at 9:50 AM, the surveyor interviewed Resident #46's Certified Nursing Aide (CNA), who stated that the resident was alert and oriented and was able to voice their needs and wants. The CNA stated that the resident required complete care for their ADLs and was continent of bladder and bowel. The CNA explained that the resident wore some sort of stockings on the lower legs, however, he did not know why. The CNA stated that the nurses applied the stockings. On 3/3/25 at 9:00 AM, the surveyor interviewed Resident #46, who stated that they usually wore unna boots (unna boot is a compression dressing made by wrapping layers of gauze around the leg and foot often used to protect an ulcer or open wound) on their bilateral lower extremities that were applied by the wound care center every Wednesday. The resident explained that the facility applied stockings on their lower extremities and that the facility nurses provided wound care to the left heel and applied the dressing on Saturday. The resident denied pain and stated that the wound on the left heel was slowly healing. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/3/25 at 9:54 AM, the surveyor interviewed the Registered Nurse (RN), who stated that the resident had a treatment order to apply tubigrip (tubular elastic bandage designed to provide tissue support and compression) on their bilateral lower extremities and a dressing on their left heel (calcaneus) three times a week. The RN stated that it was important to include any pertinent information regarding treatments, wounds, and preventative care on the resident's ICCP because the ICCP provided information about the resident and how to care for the resident. The surveyor reviewed the physician's order summary which revealed the following treatment orders: A review of the physician's order (PO) dated 2/5/25, for bilateral unna boots, full weight bearing bilaterally; must have Truvue boot bilateral (heel protector wedge boots) and change position every two hours. The resident may bear weight with a walker assist every shift for wound care. A review of the PO dated 2/27/25, indicated that the nurse was to apply tubigrip three times weekly every day shift on Tuesday, Thursday, and Saturday for left calcaneus. A review of PO dated 2/27/25, reflected an order to cleanse left calcaneus with normal saline solution (NSS); apply collagen; and cover with allevyn dressing (foam dressing) every day shift on Tuesday, Thursday, and Saturday. A review of Resident #46's ICCP included a focus area for skin alteration ICCP, but did not include that the resident wore Truvue boots, unna boots, tubigrip, or that the resident was provided with wound care to the left heel. On 3/3/25 at 10:08 AM, the surveyor interviewed the RN, who explained that the resident wore the tubigrip to the bilateral lower extremities three times weekly. The RN also stated that Resident #46 had a wound to the left heel and that a treatment to their left heel included; cleansing the wound with NSS, application of collagen, and covering the wound with an allevyn dressing on Tuesday, Thursday, and Saturday. The RN reviewed the resident's ICCP in the presence of the surveyor, and could not explain why the treatments were not documented in the ICCP. On 3/4/25 at 9:57 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who explained that the resident's ICCP was resident specific and provided a detailed account on how to take care that resident. The RN/UM stated that it was important to update the ICCP with an accurate record to include current wounds and wounds that have healed. The RN/UM continued to explain that it was also important to include preventative interventions to prevent further development of wounds and to heal existing wounds. The RN/UM stated that the ICCP should be an accurate account of what was going on with that resident and acknowledged that Resident #46's ICCP was not updated to include interventions and treatments related to their left heel ulcer. On 3/4/25 at 12:43 PM, the surveyor interviewed the Director of Nursing (DON), who acknowledged that Resident #46's ICCP should have been updated with accurate wound care interventions. The DON stated that the ICCP should include what kind of care the resident was receiving and the nurses followed the ICCP. The DON explained that any new interventions or changes in care were documented on the ICCP. A review of the facility's undated Care Plans-Comprehensive policy included that the residents ICCP would reflect treatment goals and revised as changes in the resident's condition dictate . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-11.2(e)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 33106 Based on observation, interviews, review of the clinical records and pertinent facility documentation, it was determined that the facility to a.) ensure the documentation for the administration of wound treatments for 1 of 2 residents (Resident #46) reviewed for wounds, b.) properly secure medications during medication administration observation, and c.) ensure the medication cart was locked when not in use for 1 of 4 medication carts (east high side) in accordance with professional standards of practice. Reference: New Jersey Statutes, 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 or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist: Reference New Jersey Statutes, 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 task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist. This deficient practice was evidenced by the following: 1. A review of the Admission Record face sheet (admission summary) indicated that Resident #46 was admitted to the facility with the diagnoses which included but was not limited to; chronic osteomyelitis (bone infection) and peripheral vascular disease (PVD). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 1/7/25, reflected that Resident #46 was cognitively intact and required supervision with activities of daily living (ADLs). The MDS indicated that the resident had a diabetic foot ulcer. On 2/27/25 at 10:47 AM, during tour, the surveyor observed Resident #46 in the facility gym wearing bilateral white stockings to both lower extremities. The resident was alert and oriented and had no complaints. On 3/3/25 at 9:50 AM, the surveyor interviewed Resident #46's Certified Nursing Aide (CNA), who stated that the resident was alert an oriented and was able to voice their needs and wants. The CNA stated that the resident required complete care with their ADLs and was continent of bladder and bowel. The CNA explained that the resident wore some sort of stockings on the lower legs, however, did not know why. The CNA stated that the nurses applied the stockings. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/3/25 at 9:00 AM, the surveyor interviewed Resident #46, who stated that they usually wore unna boots (unna boot is a compression dressing made by wrapping layers of gauze around the leg and foot often used to protect an ulcer or open wound) to their bilateral lower extremities that were applied by the wound care center every Wednesday. The resident explained that the facility applied stockings to their lower extremities and that the facility nurses provided wound care to the left heel and applied the dressing on Saturday. The resident denied pain and stated that the wound on the left heel was slowly healing. A review of the Wound Care Center Report (WCCR) dated 2/12/25, reflected that Resident #46 had a non-pressure related chronic ulcer to their left heel and mid-foot with the fat layer exposed. The measurements were 0.3 centimeters (cm) by (x) 0.5 cm x 0.2 cm (0.3 x 0.5 x 0.2) with a small amount of exudate (fluid that leaks out of blood vessels into the surrounding tissues) that was amber in color and medium amount of eschar (necrotic tissue). A review of the WCCR dated 2/19/25, indicated that Resident #46 had a non-pressure related chronic but stable ulcer to their left heel and mid-foot with the fat layer exposed. The measurements of the wound were smaller at 0.3 x 0.5 x 0.1. The wound had no exudate with some granulation tissue (new pink or red fleshy tissue that formed during wound healing) with a medium amount of eschar. A review of the WCCR dated 2/26/25, indicated that Resident #46 had a non-pressure related chronic ulcer to their left heel and mid-foot with the fat layer exposed. The wound continued to have some granulation tissue with medium amount of eschar. The treatment orders had changed at that time. On 3/3/25 at 9:54 AM, the surveyor interviewed the Registered Nurse (RN), who stated that the resident had a treatment order to apply tubigrip (tubular elastic bandage designed to provide tissue support and compression) to their bilateral lower extremities and dressing to the left heel (calcaneus) three times a week. The RN stated that when she received the treatment order, the order was transcribed onto the Treatment Administration Record (TAR) and then the nurse signed the TAR when the treatment was complete. The surveyor reviewed the physician's order summary which revealed the following treatment orders: A review of the physician's order (PO) dated 2/5/25, for bilateral unna boots, full weight bearing bilaterally; must have Truvue boot bilateral (heel protector wedge boots) and change position every two hours. The resident may bear weight with a walker assist every shift for wound care. A review of the PO dated 2/27/25, indicated that the nurse was to apply tubigrip three times weekly every day shift on Tuesday, Thursday, and Saturday for left calcaneus. A review of PO dated 2/27/25, reflected an order to cleanse left calcaneus with normal saline solution (NSS); apply collagen; and cover with allevyn dressing (foam dressing) every day shift on Tuesday, Thursday, and Saturday. A review of Resident #46's TAR did not include the treatment orders for the unna boots, tubigrip or treatments to the left heel. The treatment orders were not transcribed onto the TAR. There were no signatures from the nursing staff that indicated that these treatments were being administered, however the resident indicated that treatments were being provided and the wound documentation indicated that the wound was smaller and improving. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/3/25 at 10:08 AM, the surveyor interviewed the RN who explained that the resident wore the tubigrip to the bilateral lower extremities three times weekly. The RN also stated that Resident #46 had a wound to the left heel and that a treatment to the left heel included; cleansing the wound with NSS, application of collagen, and covering the wound with an allevyn dressing (foam dressing) on Tuesday, Thursday, and Saturday. The RN reviewed the TAR in the presence of the surveyor and could not explain why the treatments were not documented on the TAR. The RN stated that she was the assigned nurse that performed the treatments and she knew that they were completed. The RN acknowledged that the treatment orders were not transcribed onto the TAR as ordered by the physician and there were no nurses' signatures that indicated that the treatments were performed. On 3/3/25 at 10:18 AM, the surveyor interviewed the Infection Preventionist (IP), who stated that she was responsible to complete wound reports on the weekends and explained that she was not sure why the treatments orders were not transcribed onto the TAR and she would have to review the resident's medical record. The IP stated that after she reviewed the resident's medical record, she would get back to the surveyor. On 3/3/25 at 11:14 AM, the surveyor interviewed the IP, who stated that that the RN who took the treatment order from the physician on 2/27/25, for the tubigrip and treatment for the left heel, did not put the order in the electronic medical record (EMR) correctly resulting in the treatments not being transcribed over to the TAR. The IP stated that the RN performed the treatment on Saturday 3/1/25, however the RN did not give the IP an explanation as to why she did not sign the treatment orders. The IP stated that if the RN signed the TAR after she completed the resident's wound care, that she would have identified that the treatment was not transcribed onto the TAR. The IP reviewed the treatment order dated 2/5/25, for unna boots every shift for wound care and confirmed that the order was also not transcribed to the TAR since that date even though the unna boots were in place as ordered. The IP stated that the wound care was provided as ordered, however it was a transcription error that occurred in the EMR. On 3/4/25 at 9:57 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who explained that when a nurse took a physician's order, the nurse had to make sure the order was transcribed to either to the Medication Administration Record (MAR) or the TAR. The RN/UM stated that it was important to assure proper transcription of the order so that there were no medication errors and to assure that a treatment or medication was provided to the resident. The RN/UM stated that he had reviewed Resident #46's treatment orders and confirmed that the RN had an error in documentation and did not transcribe the treatment orders to the resident's TAR. The RN/UM stated that the RN that took the orders had performed the treatments, but she did not sign that the treatments were performed on the TAR. On 3/4/25 at 12:43 PM, the surveyor interviewed the Director of Nursing (DON), who stated that she expected the nursing staff to transcribe the treatment orders to the correct location on the TAR so that the order could be followed and completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 10:22 AM, the DON stated that the 2/5/25, the order for the unna boots was written incorrectly with no specification for monitoring, however the unna boots were not to be removed and were to be monitored for placement every shift. The DON also stated that the PO for the Truvue boots was also not transcribed correctly and should have been written specifically to include the location, time, and removal of the boots. The DON stated that the treatment orders dated 2/27/25, should have been transcribed to the TAR and that the RN had made a transcription error. The DON stated that the same RN took the PO on 2/5/25 and 2/27/25, and confirmed that the orders should have been reviewed during the 24-hour chart check to assure that the orders were complete, accurate, written and transcribed onto the TAR. A review of the facility's Orders policy dated 12/2024, included that a verbally communicated order must contain all components of a valid written order . a RN or Licensed Practical Nurse (LPN) can accept and transcribe verbal or telephone orders and that the process for accepting verbally communicated orders was that the listener would transcribe the order to the electronic medical record and under the resident's chart . A review of the facility's 24 Hour Chart Check policy dated 9/2024, included that the facility would review medical records every 24 hours to identify any physician's orders that require processing or further attention . the facility would validate that orders were transcribed correctly onto the MAR and TAR and if any discrepancies were noted, corrections would be made . 51500 2. On 2/27/25 at 9:23 AM, the surveyor observed the Licensed Practical Nurse (LPN) leave a bottle of acidophilus with pectin 100 capsules on top on the medication cart unattended and the medication cart was left unlocked, while the nurse obtained vital signs on a resident. There were no residents present by the cart at that time. On 2/27/25 at 9:41 AM, the surveyor observed the LPN leave a bottle of eye drops on the top of the medication cart unattended, while administering medications to a resident. There were no residents present by the cart at that time. On 2/27/25 at 9:52 AM, the surveyor interviewed the LPN, who stated that the medication cart could be left unlocked and unattended as long as it was up against the room doorway. The LPN stated that the medications should not be left on top of the medication cart unattended. In addition, the LPN acknowledged that the acidophilus and eye drops were left on top of the medication cart unattended. On 2/28/25 at 1:00 PM, the surveyor interviewed the DON, who confirmed that the nurse should not have left the acidophilus and eyes drops on top of the medication cart unattended. The DON stated that a nurse could not leave medications unattended and should not turn their back with medications on top to the medication cart. The DON confirmed that medication carts should be locked when unattended. A review of the facility's Medication Administration policy dated reviewed 10/2024 included: .7. No medications on top of cart. 8. Medication cart locked when not in use . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-27.1(a); 29.4(h)