

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Barnegat Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 859 West Bay Ave Barnegat, NJ 08005	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation during food preparation in a safe and consistent manner designed to prevent food borne illness by cross contamination. This deficient practice was evidenced by the following: On 3/27/2026 at 10:18 AM, during a follow-up visit to the kitchen, the surveyor observed [NAME] #1 on the preparation (prep) table wearing disposable latex gloves with a hair cover. The surveyor observed the cook pull a plastic tape from a blue box on the table, go to the large grey trash bin, lifted the lid of the bin with their gloved right hand, threw the plastic tape in the trash bin, and returned the lid of the bin. Without washing hands and changing gloves, the cook opened the blue box on the table, took out several raw frozen fish fillets from the box, and placed them on a tray. Wearing the same gloves, the cook then went inside the walk-in freezer and took out another blue box and placed it on the prep table. The cook turned around and touched the handle of the faucet and ran it from the nearby sink wearing the same gloves. The surveyor observed the cook pick up a bottle of red jam, lifted the lid of the trash bin and threw the bottle in the trash bin together with their gloves. The cook returned the lid of the bin with their bare hands. Without washing their hands first, the cook put on a new pair of gloves. The cook took several frozen fish fillets from the second blue box and placed them on a tray. Wearing the same gloves, the cook opened the oven and placed the tray of fish fillet in the oven. The surveyor then observed the cook transfer the trash bin to the dish machine area with their right hand simultaneously holding 2 frozen raw fish fillets and the right handle of the trash bin. Their left hand was holding the left handle of the bin. The cook threw the frozen raw fish fillets in the trash bin. The cook moved back the trash bin to the prep area with their gloved hands and threw their gloves in the bin. The cook replaced the lid with their bare hands. Without washing hands, the cook placed the blue boxes back in the freezer. On 3/27/2026 at 10:27 AM, the surveyor continued to observe [NAME] #1. The cook put on new pair of gloves without washing their hands first. The cook took 3 plastic bottles of spices from the spice rack. They put powdered spices in a large metal mixing bowl and mixed them with what the cook identified to the surveyor as ground tilapia. Without changing gloves and washing their hands, the cook took a deep pan and ladle. The cook ladled the spiced ground tilapia to the deep pan. Still wearing the same gloves, the cook took a box of plastic wrap and covered the deep pan. The cook took liquid lemon in green plastic bottle from the spice rack and placed it on prep table. The cook then took an aluminum foil from the prep table and covered the tray of frozen fish mixed with the ground tilapia, opened the oven cover and placed the tray inside. Still wearing the same gloves, the cook returned the bottles of spices in the spice rack. The cook took mittens and placed them on a ledge on the wall. The cook placed the large mixing bowl in the 3-compartment sink. The cook removed their gloves and threw them in the trash bin. The cook put the lid back with their bare hands. Without washing their hands, the cook put on another pair of gloves. On 3/30/2026 at 9:38 AM, during an interview with the surveyor, the Infection Preventionist (IP) stated that in the kitchen, the staff should always wash their hands first before wearing gloves. The IP further stated that staff in the kitchen should change their gloves after each task to prevent cross contamination. On 3/31/2026 at (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9:31 AM, during an interview with the surveyor, the Food Service Director (FSD) stated that they educate the dietary staff with food safety and infection control in the kitchen. The FSD further stated that the kitchen staff are expected to wash their hands before and after using gloves and that staff had to change gloves after every task. A review of the facility policy revised in August 2019, titled Handwashing/ Hand Hygiene included under Policy Interpretation and Implementation the following: 8.) Hand hygiene is the final step after removing and disposing of personal protective equipment. 9.) The use of gloves does not replace hand washing/ hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. A review of the facility policy revised in February 2023, titled Food Preparation included under Procedures the following: 2.) Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. N.J.A.C. 8:39 - 17.2 (g)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review and review of other facility documents, it was determined that the facility failed to appropriate infection control practices specifically by failing to use personal protective equipment upon entering rooms that required it when performing patient care for 2 of 8 residents reviewed under enhanced barrier precautions (EBP) (Resident #10, #101). The deficient practice was evidenced by the following: On 03/26/2026 at 9:31 AM while touring the first floor, while outside of Resident # 10's room, the surveyor observed an orange sign outside the room door that revealed a stop sign symbol and the words, Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. At that time, the surveyor observed a Certified Nurse Aide (CNA) in the room. The CNA was not wearing a gown or gloves. At that time, the surveyor observed the CNA using her barehand to pick up linens from the floor and place them in a clear plastic bag. After that, she walked to the B side of the room where Resident # 10 was in bed. The surveyor observed the CNA placing her bare hands on the resident bedside table. The CNA was then observed bagging clothing for the resident by reaching in and out of the nightstand drawers. Lastly, the CNA was observed changing the trash bag on the B side of the room. Upon leaving the room, the CNA had two clear garbage bags, one in each hand. Visible within one of the bags was an incontinence brief and trash, the other bag contained linens. On 03/27/2026 at 09:39 AM during an interview with the surveyor, the CNA said she was only asking the residents in the room if they want their showers. The CNA denied she was providing care, and she denied she wasn't wearing gloves. On 03/31/2026 at 12:00 PM during an interview with the surveyor, the Assistant Director of Nursing said, For the Enhanced Barrier Precautions portion, if staff are not interacting with devices for that portion they wouldn't need to glove or gown however if I am picking something up off the floor, one should have gloves to do so. A review of Resident # 10's Care Plan located in the Electronic Medical Record revealed a focus that, I am on Enhanced Barrier Precautions r/t [related to] history of ESBL U/A (Extended-Spectrum Beta-Lactamase; pathogen resistant to common antibiotics and may require complex treatments). N.J.A.C. 8:39-19.4(a) On 03/26/2026 at 9:39 AM surveyor #1 observed a sign on Resident #101's room door that read Enhanced Barrier Precautions: Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Care Activities . The Resident Care Activities listed on the sign included, Wound care: any skin opening requiring a dressing. At the same date and time, surveyor #1 observed an organizer hanging from Resident #101's door that contained Personal Protective Equipment (PPE) including gowns. On 03/27/2026 at 11:08 AM, with permission from Resident #101, surveyor #1 observed his/her wound care provided by Licensed Practical Nurse (LPN) #1. LPN#1 entered Resident 101's room (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	without wearing a gown. During the observation of the wound care, LPN #1 did not wear a gown throughout the entire process. At the time the wound care concluded, surveyor #1 asked LPN #1 if she should have worn a gown while providing care. LPN #1 stated that she should have worn a gown. A review of Resident #101's diagnoses located in the EMR, revealed a diagnosis of but not limited to staphylococcal arthritis of the left hip (infectious arthritis of the left hip). A review of Resident 101's physician's orders located in the Electronic Medical Record (EMR) revealed that he/she had an order for Enhanced Barrier Precautions related to wound and to irrigate left distal hip wound with acetic acid 0.25% every day and evening shift for wound healing. The order further revealed to pack wound with silver alginate (type of dressing that reduces risk of infection) and cover with a super absorbent dressing. A review of Resident #101's personalized care plan revealed a focus of Enhanced Barrier Precautions related to history of Multidrug Resistant Organism (MDRO) . and chronic wound. Interventions include, staff will wear PPE as appropriate initiated on 12/16/2024. On 03/31/2026 at 11:20 AM, during an interview with surveyor #1, the Infection Preventionist (IP) replied yes, when asked if LPN #1 should have worn a gown when performing wound care on Resident #101. A review of the facility provided policy titled, Enhanced Barrier Precautions dated December 2024 revealed, 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. and, 3. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, record review, and facility provided documentation, the facility failed to ensure that a resident did not self-administer medication without an assessment, interdisciplinary care team meeting determination, a physician's order, or care plan intervention for 1 of 3 residents (Resident #28) reviewed for the Medication Administration task. This deficient practice was evidenced by the following: During observation of medication administration on 03/27/2026 at 9:33 AM, Resident #28 told Licensed Practical Nurse (LPN) #1 that they had already administered their eye drops. Resident #28 stated, I have them in my drawer; I do it myself. When the LPN asked, You give yourself the eye drops? the resident confirmed. The surveyor then asked the LPN whether Resident #28 self-medicated their eye drops, and the LPN stated, Yes. A review of Resident #28's admission Record revealed diagnoses including, but not limited to, Alcohol Abuse with Withdrawal Delirium, Attention Deficit Hyperactivity Disorder, and Post-Traumatic Stress Disorder. A review of the physician's orders on 03/27/2026 revealed an order dated 09/08/2025 for Refresh Celluvisc Ophthalmic Gel 1%: instill one drop in both eyes two times a day for dry eyes. There was no physician order authorizing the resident to self-administer this medication. A review of the Care Plan revealed no focus, goal, or intervention related to self-administration of medication prior to the surveyor bringing the matter to the LPN Unit Manager's attention. A review of the Electronic Medical Record revealed no Medication Self-Administration Safety Screen completed prior to 03/27/2026. During an interview on 03/27/2026 at 12:45 PM, the second-floor LPN Unit Manager stated that for a resident to self-medicate, an assessment must be completed, an interdisciplinary team (IDT) meeting must occur, and a physician's order must be in place. The LPN Unit Manager stated that no residents on the unit were approved to self-medicate. When asked specifically about Resident #28, the LPN Unit Manager stated, I did not know this was happening. The LPN Unit Manager further stated that Resident #28 did not have anything in place authorizing self-administration. During an interview on 03/31/2026 at 12:01 PM, the Director of Nursing (DON) stated that residents may self-administer medications only after an evaluation by therapy and the IDT to determine safety. The DON stated that a physician's order and a care plan intervention addressing self-administration must also be in place. The DON stated that these steps are necessary to ensure resident safety. A review of the facility provided policy titled Self-Administration of Medication revealed: Residents have the right to self-administer medications if the IDT has determined that it is clinically appropriate and safe for the resident to do so. N.J.A.C. 8:39-29.2(c)		

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, it was determined that the facility failed to ensure that the results of the most recent survey were readily accessible to residents and the public. The deficient practice was evidenced by the following: On 03/26/2026 at 09:52 AM during the initial tour, the surveyor observed the State Survey Binder located in the lobby of the facility. At that time, the surveyor did not observe any Life Safety Code Statement of Deficiencies (CMS-2567) from previous surveys within the binder. On 03/31/2026 at 12:00 PM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) replied I will check after the surveyor asked if there is a reason the Survey Binder does not include any Life Safety Code Statements of Deficiencies. On 04/01/2026 at 10:25 AM during an interview with the surveyor, the LNHA said that the Life Safety Code Statement of Deficiencies is now included in the Survey Binder. N.J.A.C. S 8:39-13.1(a)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to maintain the residents' living environment in a clean, sanitary, and homelike manner for 2 of 2 units (First and Second Floor). This was evidenced by: On 03/26/2026 at 10:06 AM, Surveyor #1 observed the first-floor shower room. In the first shower stall, on the bottom left corner, Surveyor #1 observed black discoloration and several chipped tiles. During an interview on 03/30/2026 at 11:15 AM, the Assisitant Director of Nursing (ADON) stated that housekeeping was responsible for the major cleaning of the shower room. Surveyor #1 and the ADON reviewed the shower room together. The ADON acknowledged that the shower tiles need attention. During the initial tour on 03/26/2026 at 9:26 AM, the surveyor observed room [ROOM NUMBER]A. At that time, the surveyor observed that the wallpaper was ripped behind the bed. The surveyor then observed room [ROOM NUMBER]. At that time, the surveyor observed, below the window, that there was a gap between the air conditioner/heater unit and the drywall above, with a black vegetative substance present within the gap. During the initial tour on 03/26/2026 at 9:42 AM on the second floor, the surveyor observed in the shower room cracked tiles, a clump of hair in the corner, and a black substance around the middle shower floor. During rounds on 03/27/2026 at 9:15 AM, the surveyor observed that the sink in the bathroom of room [ROOM NUMBER] had caulk that was cracked and peeling, with a gap between the wall and the sink. During an interview on 03/31/2026 at 12:01 PM with the survey team, the Licensed Nursing Home Administrator (LNHA) stated that the facility is toured daily by maintenance and the ambassador team (a team of managers). The LNHA stated that they try to be diligent in ensuring the facility is treated as they would treat their own homes. The LNHA also stated that they try to ensure it is a homelike environment for the residents. A review of a facility-provided policy titled Homelike Environment revealed: 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary, and orderly environment. N.J.A.C. 8:39-31.4(f)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility did not ensure a residents medication regimen was free from unnecessary psychotropic medications. Specifically, a psychotropic medication ordered for an extended duration lacked documented clinical rationale in the resident's record. The deficient practice was identified for 1 of 5 residents (Resident #41) reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 03/26/2026 at 12:43 PM, the surveyor observed Resident #41 walking the facility halls speaking incoherently to themselves. A review of the Electronic Medical Record (EMR) under Diagnoses revealed that Resident #41 was diagnosed with but not limited to generalized anxiety disorder and unspecified dementia (a decline of cognitive function). A review of Resident #41's Minimum Data Set (MDS; an assessment tool used to facilitate the management of care) dated 03/11/2026, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which indicated that Resident #'s 41's cognition was severely impaired. A review of Resident #41's physician's orders found in the EMR revealed an order for Lorazepam (a psychoactive medication) oral concentrate 2MG/ML (milligrams per milliliter) with a start date of 03/03/2026. The order further instructed to give 0.25ml by mouth every 6 hours as need (PRN) for anxiety for 90 days Hospice. Further review of Resident #41's EMR did not reveal any documented rationale for ordering Lorazepam PRN for an extended duration (90 days). On 03/31/2026 at 12:02 PM during an interview with the surveyor the Director of Nursing (DON) stated that the physician's assessment should indicate the need for the extended duration of use of the medications prescribed. A review of the facility policy titled, Psychotropic Medication Use revised July 2022 revealed under Policy Interpretation and Implementation under number 12, a. PRN orders for psychotropic medications are limited to 14 days. The policy further revealed, . if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he/she will document the rationale for extending the use and include the duration for the PRN order. N.J.A.C. 8:39-27.1(a)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was accurate by relying solely on an initial assessment performed by a Licensed Practical Nurse (LPN) without further RN clinical verification for 1 of 1 resident (Resident # 36) reviewed for assessment accuracy. The deficient practice 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 registered professional nurse is defined as diagnosing and treating human responses to actual and 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 regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. 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. 03/26/2026 10:11 AM Resident # 36 was observed to have a subclavian access device, identified as a central venous access device. The resident showed the surveyor the site on his/her chest. The Resident stated there are still sutures underneath. A review of the Resident's Electronic Medical Record under Medical Diagnoses revealed a diagnosis of but not limited to Encounter for Other Orthopedic Aftercare, and Osteomyelitis of vertebra lumbar region along with Methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere. A review of the physician's orders revealed an order for oxacillin sodium intravenous solution reconstituted. The order revealed to use 12 grams intravenously one time a day for MSSA (Type of staph bacteria, differentiated primarily by their resistance to methicillin and similar antibiotics) epidural abscess until 03/29/2026, Oxacillin 12 grams in normal saline 500 milliliter (ml) at 21ml/hour over 24 hours. A review of Resident # 36's Admission/readmission Evaluation located in the Electronic Medical Record revealed that it was completed on 02/28/2026 by a Licensed Practical Nurse. A review of the section Z of the Minimum Data Set (an assessment tool) audit revealed the MDS Coordinator RN's (Registered Nurse) signature; that verifies the assessment completion. It was dated 3/7/2026. On 03/27/2026 at 11:43 AM during an interview with the surveyor, the MDS Coordinator RN replied That's the admission nursing assessment when the surveyor asked what the significance of the Admission/readmission Evaluation was. The surveyor asked if as the RN, she performs a physical assessment on the resident prior to signing section Z of the MDS. The MDS Coordinator RN replied, The LPN does the admission assessment and then I use that information for the MDS. Lastly, she said if at any time, something doesn't line up or is in question, she prefers to review the electronic form before she locks it. On 03/31/2026 at 12:00 PM during an interview with the surveyor, the Director of Nursing replied, I believe she [MDS Coordinator RN] can sign based on an LPN initial assessment after the surveyor asked should the MDS Coordinator RN physically assess the resident before she signs and completed the MDS or can she sign and complete the MDS based off of an LPN initial assessment. A review of the facility-provided policy titled, Resident Assessments revised March 2022 revealed, 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. N.J.A.C. S 8:39-11.1		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to ensure that nursing assessments for falls were completed by a Registered Nurse (RN) and fall care plans were formulated and evaluated for effectiveness by an RN, in accordance with professional standards of practice. This deficient practice was identified for 1 of 4 residents (Resident #10) reviewed for accidents. This deficient practice 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 registered professional nurse is defined as diagnosing and treating human responses to actual and 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 regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. 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. On 03/26/2026 at 9:45 AM, the surveyor observed Resident #10 sleeping in bed. The surveyor reviewed the electronic medical record (EMR) for Resident #10. A review of the admission Record face sheet (an admission summary) reflected that Resident #10 was admitted to the facility with diagnoses which included but were not limited to the following: dementia, history of falling, and bipolar disorder (a mental health condition characterized by extreme mood swings). A review of the most current quarterly Minimum Data Set (MDS), an assessment tool dated 1/16/2026, revealed the resident had severely impaired cognition and multiple falls since admission. A review of the nursing progress notes (PN) revealed that the resident fell on the following dates with no documented assessments by an RN: 5/29/2025, 7/27/2025, 8/2/2025, 8/21/2025, 11/1/2025, 12/3/2025, 12/9/2025, 1/9/2026, 1/17/2026, 1/26/2026, 2/4/2026, and 2/9/2026. A review of the individual comprehensive care plan (ICCP) included a focus area initiated on 5/23/2025 by Licensed Practical Nurse/ Unit Manager (LPN/ UM) #1, that the resident was at risk for falls. This focus and the corresponding goal have not been updated to reflect the multiple falls that the resident had. The interventions for falls did not include any intervention by an RN corresponding with falls on the following dates: 5/29/2025, 7/27/2025, 8/2/2025, 8/21/2025, 11/1/2025, 12/3/2025, 12/9/2025, 1/9/2026, 1/17/2026, 2/4/2026, and 2/9/2026. On 3/27/2026 at 1:02 PM, during an interview with the survey team, LPN/ UM #1 stated that the LPNs do the initial assessment and initiate the care plans of newly admitted residents. On 3/30/2026 at 12:46 PM, during an interview with the survey team, LPN/ UM #2 stated that they do not think that only RNs can assess new admissions and formulate care plans. On 3/31/2026 at 12:10 PM, during an interview with the survey team, the Director of Nursing (DON) stated that LPNs can assess falls. The DON further stated that the unit managers, who are both LPNs, formulate the care plans for falls, as well as put the goals and interventions after meeting as a team. The DON confirmed that whoever formulates the care plans and evaluates its effectiveness is documented in the (EMR). A review of facility policy revised in March 2018, titled Falls and Fall Risk, Managing did not define who can assess a resident's fall. There was no indication in the policy to delineate if an RN or LPN could complete an assessment. A review of facility-provided document revised in December 2021, titled Job Description - Registered Nurse included under Duties and Responsibilities the following: Provides accurate and timely documentation consistent with plan of care. A review of facility-provided document revised in December 2021, titled Job Description - Licensed Practical Nurse included under Duties and Responsibilities the following: Implements plan of care formulated by physician and Registered Nurse. N.J.A.C. 8:39 - 11.1		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to ensure that appropriate incontinence care was provided for a resident who was dependent on staff for toileting hygiene and incontinence care. This deficient practice was identified for 1 out of 3 residents (Resident #70) reviewed for bladder and bowel incontinence. The deficient practice was evidenced by the following: On 3/26/2026 at 9:40 AM, during the initial tour of the facility, the surveyor observed a malodorous smell on the first-floor unit hallway across the room of Resident #70. The surveyor observed Certified Nursing Assistant #1 (CNA #1) 1 enter Resident #70's room. On 3/26/2026 at 9:56 AM, the surveyor observed the door to the resident's room open. From the hallway, the surveyor observed CNA #1 fixing Resident #70's hair. When CNA #1 exited the room, the surveyor asked the CNA how many residents were in their assignment. CNA #1 stated they have 16 residents in their assignment. The surveyor entered the room of Resident #70. The surveyor observed the resident sitting in their wheelchair. The room smelled malodorous of urine. The surveyor noted the resident's dark blue mattress without a bed sheet. The mattress was wet and had a very strong smell of urine. The resident stated that the last time they got changed was yesterday morning. On 3/26/2026 at 10:00 AM, the surveyor looked at the CNA Assignment Sheet of the first floor. CNA #1 was assigned to residents in rooms 124 A, 124 B, 125 A, 125 B, 126 A, 126 B, 127 A, 127 B, 128 A, 128 B, 129 A, 129 B, 130 A, 130 B, 131 A, and 131 B for a total of 16 residents. On 3/27/2026 at 9:35 AM, during an incontinence tour of the first-floor unit with Licensed Practical Nurse/ Infection Preventionist (LPN/ IP), the surveyor observed Resident #70 in bed. LPN/ IP exposed the resident's blue incontinence brief from the front and the back. Both front and back of the brief was soaked with urine. The surveyor observed a malodorous smell of urine when the resident's brief was exposed. Under the resident was a blue disposable bed liner. The surveyor asked the resident when they last got changed. The resident stated that the last time they got changed was yesterday morning. The skin on the resident's buttocks area was not red. The surveyor reviewed the electronic medical record of Resident #70. A review of the resident's admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to pressure-induced deep tissue damage of the sacral (lower back) region, cerebrovascular disease, and congestive heart failure. A review of the resident's most current comprehensive Minimum Data Set (MDS), an assessment tool dated 3/18/2026, revealed that the resident had severely impaired cognition. The MDS further revealed that the resident required maximal assistance from staff for toileting hygiene and that the resident was frequently incontinent with bowel and bladder. A review of the Order Summary Report active as of 3/26/2026, revealed a physician order for furosemide 20 milligrams/ day indicated for congestive heart failure. A review of the Point-of-Care (POC) documentation (care staff documentation of care activities in the EMR) in March 2026, revealed no documentation that the resident received incontinence care for bladder during the following shifts and dates: a.) day shift on 3/11/26, 3/13/26, 3/20/26, 3/21/26, 3/22/26, 3/27/26, and 3/28/26; b.) evening shifts on 3/11/26, 3/14/26, 3/15/26, 3/16/26, 3/17/26, 3/19/26, 3/20/26, 3/22/26, 3/23/26, 3/24/26, 3/27/26, 3/28/26, and 3/29/26; and c.) night shift on 3/19/26 and 3/24/26. A review of the individual comprehensive care plan (ICCP) included a problem area initiated on 3/11/2026, that the resident required assistance for toileting related to recent cerebrovascular accident (stroke). On 3/30/2026 at 10:00 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that staff is expected to check residents for incontinence every 2 hours. On 3/30/2026 at 11:45 AM, during an interview with the surveyor, the Staffing Coordinator (SC) stated that they were aware of the minimum direct care staffing ratio in New Jersey and that they were 1 CNA to 8 residents in the day shift. On 3/30/2026 at 12:11 PM, during an interview with the surveyor, the DON stated that they were aware of the minimum direct care staffing ratio in New Jersey and that they were 1 CNA to 8 residents in the day shift. A review of facility policy revised in April 2018, titled (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Urinary Incontinence - Clinical Protocol included under Treatment and Management the following: As appropriate, based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status. N.J.A.C. 8:39 - 27.1 (a); 27.2 (d) (h) (j)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, review of medical record and other pertinent facility documentation, it was determined that the facility failed to ensure that a resident who was identified as having a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity or rigidity of joints) received services to prevent further decreased range of motion (ROM) after discharge from therapy. This deficient practice was identified for 1 of 1 resident (Resident #25) reviewed for position and mobility. This deficient practice was evidenced by the following: On 3/26/2026 at 10:07 AM, the surveyor observed Resident #25 in bed. The surveyor observed the resident's right fingers flexed with short nails visible. The surveyor asked the resident if they could open their right hand. The resident's right fingers were observed with little movement but remained flexed. The surveyor observed the skin on the right palm dry under the nails with no redness. The surveyor asked the resident if the staff apply anything on their right hand. The resident stated that staff do not put anything on their right hand. The surveyor did not observe any device for the right hand in the resident's room. On 3/26/2026 at 11:40 AM, the surveyor observed the resident come out of the first-floor dining room in their wheelchair, holding a can of soda on the left hand. The surveyor did not observe any splint (a medical device, also termed an orthosis, designed to support, immobilize, or improve the function of the hand, wrist or fingers) on the right hand. On 3/26/2026 at 12:23 PM, the surveyor observed the resident in the hallway in front of the nurses' station. The resident stated that they finished their lunch. The surveyor did not observe a splint on the resident's right hand. On 3/27/2026 at 9:10 AM, the surveyor observed the resident in the hallway in front of the nurses' station in their wheelchair. The resident was not wearing a hand splint on their right hand. The surveyor reviewed the electronic medical record (EMR) of Resident #25. A review of the admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to the following: contracture of the right hand, foot drop of the right foot, and dementia. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 1/7/2026, reflected that Resident #25 had intact cognition. A review of the Order Summary Report (OSR) active as of 3/26/2026, included the following orders: Right resting hand splint as tolerated, every day and evening shift for right hand contracture, to be worn up to 8 hours a day as tolerated. Document tolerance of brace and refusals. A review of the corresponding March 2026 Treatment Administration Record (TAR) revealed that the right hand splint was administered (checked) during day shift on 3/26/2026 and 3/27/2026. A review of the progress notes (PN) dated 3/27/2026 to 3/27/2026 did not reveal any documented reference to the resident's refusal to wear the splint. A review of the individual comprehensive care plan initiated on 10/10/2024, included a focus for right hand splint use. The care plan has not been updated or revised since it was initiated in 2024. A review of the resident's Occupational Therapy (OT) report revealed that the resident finished an OT service from 1/14/2026 to 2/23/2026. The discharge recommendations included the following: Remain consistent with splint wearing schedule - 8 hours a day as tolerated. On 3/30/2026 at 9:27 AM, the surveyor observed the resident in their wheelchair wearing a right-hand splint. On 3/31/2026 at 9:35 AM, the surveyor observed the resident in the hallway without a hand splint. The surveyor asked their primary nurse, LPN # 1, why the resident was not wearing a hand splint. LPN #1 stated that it was the resident's shower day. The nurse further stated that the resident had shower days on Tuesdays and Fridays during day shift. The surveyor asked the nurse what time the resident's shower was. The nurse could not state what time was the resident's shower. The surveyor asked the nurse why the resident was not wearing their splint last week. The nurse stated that the resident refused to wear it. The surveyor observed the resident agreed to wear their splint when asked by the nurse. The surveyor observed the nurse applied the splint to the resident's right hand with no visible signs of discomfort. The (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor asked the nurse again why the resident was not wearing their splint last week. The nurse stated, I did not realize that they were not doing it. On 3/30/2026 at 9:43 AM, during an interview with the surveyor, the Director of Rehabilitation (DOR) stated that the expectation is for the nursing staff to apply the orthoses when they are ordered by the physician. The DOR further stated that the hand splint is usually ordered to prevent further increase in a resident's contracture. On 3/30/2026 at 10:00 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that a check mark in the TAR meant an order was administered. When an order is not administered or if the resident refuses an order, it will be marked as #2. A review of facility policy revised in July 2017, titled Resident Mobility and Range of Motion included under Policy Statement the following: .2.) Residents with limited range of motion will receive treatment and services to increase and/ or prevent a further decrease in ROM. N.J.A.C. 8:39-27.1(a), 27.2(m)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility provided information, it was determined that the facility failed to ensure that a resident at risk for elopement had complete and accurate physician orders and consistent monitoring of a wander guard device following readmission from the hospital. The deficient practice was identified for 1 of 1 Resident (Resident # 52) reviewed for elopement. This deficient practice was evident by the following: During the initial tour on 03/26/2026 at 10:23 AM, the surveyor observed Resident #52 in bed with a wander guard device (a device that may trigger an audible sound when the wearer passes through an exit doorway) on the right ankle. A review of Resident #52's admission Record showed diagnoses including dementia, major depressive disorder, and Alzheimer's disease. The resident's Care Plan, initiated on 01/15/2024, identified a risk for elopement with an intervention for the resident to wear a wander Guard. A review of the Physician Order Summary revealed an order dated 03/26/2026 at 23:00 stating, wander Guard to right ankle, check for proper placement every shift. There was no order to check the device for function. A review of the Medication Administration Record (MAR) for February 2026 showed a previous order stating, wander guard applied to left ankle, check function every day. A review of the Electronic Medical Record (EMR) revealed the resident was sent to the hospital on [DATE] for seizure activity and readmitted on [DATE]. A progress note dated 02/13/2026 at 20:36 documented that the nurse practitioner instructed staff to continue the wander guard. A review of the daily wander guard check book revealed that Resident #52's wander Guard was checked for placement throughout February 2026. For March 2026, Resident #52 was not listed on the checklist, and there was no documentation of placement or function checks. During an interview on 03/27/2026 at 12:44 PM, the Licensed Practical Nurse Unit Manager (LPNUM) stated that Resident #52 had worn a wander guard for years and was known to wander throughout the unit. The LPNUM stated that the device is removed only when the resident is sent to the hospital and reapplied upon return. The LPNUM acknowledged that she forgot to reinstate the wander guard orders after the resident's readmission and confirmed that the resident should also have had an order to check function. During an interview on 03/31/2026 at 12:01 PM, the Director of Nursing (DON) stated that residents with Wander Guards must have orders to check both placement and function to ensure proper monitoring of elopement risk. The DON stated that it is important to reinstate all necessary orders after hospitalization to ensure residents receive appropriate care. A review of the facility's policy titled Wandering and Elopements stated that the facility will identify residents at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment. N.J.A.C. 8:39-27-1 (a)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, and pertinent facility documentation, it was determined that the facility failed to ensure that an indwelling urinary catheter (tube inserted in the bladder to drain urine) drainage bag was secured in a manner to prevent contamination and provide appropriate and sufficient services based upon current standards of practice and the resident's comprehensive care plan to document urinary output in the Treatment Administration Record (TAR). The deficient practice was identified for 1 of 1 resident (Resident # 3) investigated for Urinary Catheter or UTI. The deficient practice was evidenced by the following: On 03/27/2026 at 9:31 AM, the surveyor observed Resident #3 seated in a wheelchair in the dining room, the urinary drainage bag was observed below the resident's wheelchair in direct contact with the floor. On the same day at 9:33 AM, during an interview with the surveyor, Certified Nurse Aide (CNA) #1 stated that urinary drainage bags should be stored below the waist and should not make contact with the floor. A review of the electronic Medical Record (EMR) under Diagnoses revealed that Resident #3 was diagnosed with but not limited to urinary tract infection and retention of urine (inability to fully empty the bladder). A review of the quarterly Minimum Data Set (An assessment tool) dated 03/02/2026 revealed under section, H that Resident # 3 had an indwelling catheter. A review of the EMR revealed an active physician's order to monitor urine output every shift with a start date of 07/28/2025 and to monitor for signs and symptoms of infection every shift. A review of Resident #3's personalized Care Plan revealed a focus of, suprapubic catheter related to obstructive uropathy (condition in which the flow of urine is blocked) initiated on 12/04/2024. The focus further revealed intervention that included, monitor/record/report to MD for . cloudiness, no output. A review of Resident # 3's Treatment Administration record for March, 2026 revealed blank sections of documentation to monitor urine output every shift on the following dates and shifts: 03/03/2026 evening and night shift blank 03/26/2026 night shift blank 03/28/2026 day shift blank 03/30/2026 day shift blank A review of Resident # 3's Treatment Administration record for February, 2026 revealed blank sections of documentation to monitor urine output every shift on the following dates and shifts: 02/01/2026 night shift blank 02/04/2026 day shift blank 02/11/2026 day shift blank 02/26/2026 night shift blank 02/27/2026 night shift blank 02/28/2026 day shift blank A review of Resident # 3's Treatment Administration record for January, 2026 revealed blank sections of documentation to monitor urine output every shift on the following dates and shifts: 01/03/2026 night shift blank 01/12/2026 night shift blank 01/29/2026 day shift blank 01/30/2026 night shift blank 01/31/2026 night shift blank A review of Resident # 3's Treatment Administration record for December, 2025 revealed blank sections of documentation to monitor urine output every shift on the following dates and shifts: 12/03/2025 evening shift blank 12/08/2025 day shift blank 12/17/2025 night shift blank 12/20/2025 night shift blank On 03/31/2026 during an interview with the surveyor, the Director of Nursing (DON) stated that no output of urine would indicate a health concern. The DON further stated that documentation of urine output would indicate potential complications when asked of the importance of urine output documentation for residents with urinary catheters. A review of the facilities policy titled, Catheter Care, Urinary revised August 2022 revealed under the section titled Purpose that the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. The policy further revealed under the section titled Infection Control to 2. Be sure the catheter tubing and drainage bag are kept off the floor. The policy further revealed under the section titled Input/Output to 1. Observe the resident's urine level for noticeable increases or decreases. N.J.A.C. S 8:39-27.1 (a)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice specifically by leaving a nasal cannula out of a bag, exposed to air and not having a physician's order for oxygen administration. The deficient practice was identified for 1 of 1 (Resident # 12) residents reviewed for Respiratory Care. The deficient practice was evidenced by the following: On 03/26/2026 at 9:47 AM, during the initial tour, the surveyor observed Resident #12 in their room. At that time, the surveyor observed a nasal cannula (tube that delivers oxygen through the nares) resting on top of an oxygen concentrator and a nebulizer (machine that aerosolizes medication for inhalation) mask stored in the resident's bedside table. The nasal cannula and nebulizer mask were not in a bag and were exposed to air. At that time, during an interview with the surveyor, Certified Nurses Aide (CNA) #1 stated, that was not the way the oxygen tubing and nebulizer mask should be stored and stated they should be in a bag. On 03/27/2026 at 9:15 AM, the surveyor observed Resident #12 in their bed with the nasal cannula applied. A review of Resident #12's admission record revealed he/she was admitted to the facility with diagnosis including but not limited to chronic systolic (congestive) heart failure (when the heart muscle does not pump blood as well as it should) and dementia (a decline of cognitive function). A review of Resident # 12 order summary report dated 3/26/2026 revealed an order for hospice care and did not show any orders for oxygen. During an interview on 03/27/2026 at 10:28 AM, with Unit Manager (UM) when asked if Resident #12 had an order for oxygen, UM #1 confirmed that there was no order for oxygen. The UM further indicated that it was important to have an order because anything given to the resident must be based on a physician's order. During an interview on 03/31/2026 at 12:02 PM, the Director of Nursing (DON) stated yes when asked if there should be a physician's order for oxygen if a resident is being administered oxygen. The DON further stated, oxygen is considered a medication and should be monitored and ordered by the physician. A review of the facility policy titled Oxygen Administration revised October 2023 revealed under Preparation section, 1. Verify that there is a physicians order for this procedure. A review of the policy titled Administering Medications through a Small Volume (Handheld) Nebulizer revised October 2010 revealed under Steps in the Procedure section, 29. store in a plastic bag with the residents name and date on it. N.J.A.C. S 8:39-27.1		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility provided information, it was determined that the facility failed to ensure that a resident (Resident #2) with a prescribed fluid restriction had monitoring orders in place and documented intake as required for 1 of 1 resident reviewed for dialysis. This deficient practice was evidenced by the following: On 03/27/2026 at 09:19 AM, the surveyor observed Resident #2 in bed with a cup on the bedside table. Resident #2 voiced no concerns at that time. A review of Resident #2's admission record revealed diagnoses including, but not limited to, End Stage Renal Disease (kidneys do not function properly).A review of the electronic medical record showed that Resident #2 was admitted to the hospital on [DATE] for hyperpotassemia (elevation of potassium in the blood) and was readmitted to the facility on [DATE].A review of the March 2026 Medication Administration Record (MAR) revealed a previous order for a 1000 milliliter (mL) fluid restriction (660 mL dietary, 340 mL nursing) with shift-specific monitoring (7-3 shift: 120 mL; 3-11 shift: 120 mL; 11-7 shift: 100 mL). This order had a start date of 08/29/2025 and was discontinued on 03/16/2026.A review of the Physician's Order Summary dated 03/19/2026 revealed a new order for a renal diet with a 1000 mL daily fluid restriction.No corresponding monitoring order was entered into the MAR following the resident's readmission on [DATE].During an interview on 03/27/2026 at 11:22 AM, the Assistant Director of Nursing (ADON) stated that Resident #2 should have been monitored for fluid restriction and that such monitoring should be documented in the MAR. After reviewing the resident's electronic MAR, the ADON stated, It must have gotten forgotten when he/she was readmitted .During an interview on 03/27/2026 at 12:45 PM, the second floor LPN Unit Manager stated that fluid restrictions must be documented on the MAR to ensure intake is monitored. The LPN Unit Manager stated that Resident #2 should have had orders in the MAR requiring staff to sign off each shift on the amount of fluid consumed.A review of the facility's policy titled Encouraging and Restricting Fluids revealed the following under General Guidelines:1. Follow specific instructions concerning fluid intake or restrictions, and 3. Record fluid intake on the intake side of the intake and output record. Record fluid intake in mLs.N.J.A.C. 8:39-27.1(a)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Barnegat Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 859 West Bay Ave Barnegat, NJ 08005	
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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to ensure Licensed Practical Nurse staff practiced within their professional scope of practice. The facility permitted Licensed Practical Nurses (LPNs) to independently conduct initial nursing assessments and initiate resident care plans without Registered Nurse (RN) coordination or oversight. The deficient practice was identified for 1 of 1 resident (Resident # 36) reviewed under the Competent and Sufficient Nursing Staff. The deficient practice 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 registered professional nurse is defined as diagnosing and treating human responses to actual and 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 regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. 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. On 03/26/2026 at 10:11 AM during the initial tour, the surveyor observed Resident # 36 in his/her room. He/She was admitted on [DATE]. At that time, the surveyor observed an intravenous (IV) pole with an IV bag connected to a tube that was infusing into the resident. A review of Resident # 36's Medical Diagnoses in the Electronic Medical Record (EMR) revealed a diagnoses of but not limited to Encounter for Other Orthopedic Aftercare, and Osteomyelitis of vertebra lumbar region (a serious, often post-operative or hematogenous, infection) along with Methicillin susceptible staphylococcus aureus infection (a type of bacterium responsible for difficult-to-treat infections due to its resistance to many common antibiotics) as the cause of diseases classified elsewhere. A review of the physician's orders in the EMR revealed an order for oxacillin sodium intravenous solution reconstituted (an antibiotic). The order revealed to use 12 grams intravenously one time a day for MSSA (Methicillin-Susceptible Staphylococcus aureus, a strain of staph bacteria that causes infections but remains susceptible to treatment with penicillin-related antibiotics) epidural abscess until 03/29/2026, Oxacillin 12grams in Normal Saline 500 milliliter at 21ml/hour over 24 hours. A review of the Care Plan located in the Medical Record revealed a focus for Right internal jugular (Central Line) secondary to infection/antibiotic therapy. It was created on 2/28/2026 by the Licensed Practical Nurse (LPN). There was also a focus for IV Antibiotic therapy via right Inter Jugular (Central Line) related to MSSA epidural abscess. It was initiated on 2/28/2026 and created by an LPN. A review of the Admission/readmission Evaluation located in the EMR dated 02/28/2026, revealed that it was completed by an LPN. On 03/27/2026 at 1:02 PM during an interview with the surveyor, the first floor LPN Unit Manager (LPN/UM) # 1 said that once the admission assessment is done, medications are verified with the prescriber, she will review the hospital records for a resident and initiate care plans at that time. The surveyor asked, If there is any LPN, they do the initial assessment? The LPN/UM # 1 replied, Yes. Lastly, she said that some of the nurses do know how to start the care plans including LPNs. She concluded by saying they will just start the head-to-toe assessment if they need to and they will start the care plan. On 03/29/2026 at 12:33 PM during an interview with the surveyor, the second floor Unit Manager, an LPN (LPN/UM) # 2, described that when the facility has a new admission, she will initiate a head-to-toe assessment. She continued by saying that the nurses do the other assessments including the Admission/readmission Evaluation and Base Line Care Plan. At that (continued on next page)		

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Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Barnegat Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 859 West Bay Ave Barnegat, NJ 08005	
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time, the LPN/UM # 2 said that the Licensed Practical Nurses do the admission initial assessment but for the most part, she does them. When the surveyor asked if a Registered Nurse over sees that, she replied that she assumes the Director of Nursing looked over these. She stated, I don't know when asked if there is a designated Registered Nurse. On 03/31/2026 at 12:00 PM during an interview with the surveyor, the Director of Nursing replied, They do the initial resident evaluations. We do a review as a team after the surveyor asked if there is a reason Licensed Practical Nurses are doing initial assessments on newly admitted residents. During the same interview with the surveyor, the Director of Nursing replied, I don't have a good answer. The reason is we direct them to do so after the surveyor asked if there is a reason Licensed Practical Nurses are initiating base line care plans on newly admitted residents. A review of the facility-provided job description document revised 12/21 titled, Licensed Practical Nurse (LPN) revealed under Duties and Responsibilities that the LPN can, Provide basic nursing care to patients within Post-Acute and Rehabilitation's scope of practice including actions that meet psychosocial needs and physical needs. Secondly, it revealed that the LPN, Provide direct and individualized nursing care to assigned patients based on nursing standards and under the supervision of the Director of Nursing and/or a Registered Nurse designee. Lastly, the document revealed that the LPN Implements plans of care formulated by physician and Registered Nurse. A review of the facility-provided job description document revised 12/21 titled, LPN Unit Manager revealed under Purpose of Your Job Position that, The primary purpose of your position is to assist the Director of Nursing Services in planning organizing, developing, and directing the day-to-day functions of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the Facility, and as may be directed by the Administrator, the Medical Director, and/or Director of Nursing Services, to ensure that the highest degree of quality care is maintained at all times. N.J.A.C. S 8:39-11.1		