STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Bayshore LLC	715 North Beers Street Holmdel, NJ 07733

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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 49094 NJ Complaint # NJ169941 Based on interview, review of the closed medical record, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident was sufficiently prepared for a discharge from the facility by providing a prescription for an active antibiotic treatment. This deficient practice was identified for 1 of 2 residents reviewed for discharge (Resident #239), and was evidenced by the following: On 10/28/24 at 10:23 AM, the surveyor reviewed the closed medical record for Resident #239 which revealed the resident was admitted to the facility in 2023 and discharged from the facility in 2023. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses including but not limited to; displaced trimalleolar fracture of left lower leg (severe injury that affects the ankle joint), infection and inflammatory reaction due to internal right hip prosthesis (infection around the right hip replacement implant), and methicillin resistant staphylococcus aureus infection (infection that is resistant to several antibiotics). A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 11/2/23, indicated that the resident had a brief interview for mental status (BIMS) score of 6 out of 15, which indicated severe impaired cognition. A review of the Physician Order Summary Report reflected a physician's order with a start date of 11/26/23 at 2:00 PM, for clindamycin HCL oral capsule (antibiotic used to treat serious infections) 300 milligrams (mg); give one capsule by mouth every eight hours related to infection and inflammatory reaction due to internal right hip prosthesis, subsequent encounter. There was no stop date per infectious disease. A review of the December 2023 Medication Administration Record (MAR) revealed Resident #239 received the clindamycin HCL oral capsule 300 mg at 6:00 AM, 2:00 PM, and 10:00 PM from 12/1/23 to 12/22/23. A review of the discharge summary dated 12/21/23, indicated that the resident was scheduled for discharge on 12/22/23, to an assisted living facility. (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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the New Jersey Universal Transfer Form revealed that Resident #239 was discharged from the facility on 12/22/23 at 12:30 PM. The resident was transferred to an assisted living facility. On 10/28/24, the surveyor requested copies of the prescriptions that were given to the resident upon discharge. A review of the prescriptions revealed that the resident received the following prescriptions dated 12/22/23: glycolax powder (Miralax), apixaban 5 mg (anticoagulant), sertraline HCL 100 mg (antidepressant), Advair Diskus 250/50 micrograms per actuation (mcg/act)aerosol powder (oral inhaler), mirtazapine 15 mg (antidepressant), melatonin 5 mg (used for insomnia), losartan 100 mg (blood pressure), hydralazine 25 mg (blood pressure), levothyroxine 125 mcg (thyroid), Vitamin D3 400 unit, alogliptin 25 mg (diabetic), calcium carbonate 500 mg, acidophilus tablet (probiotic), atorvastatin 40 mg (cholesterol), Cardizem ER 360 mg (prevent chest pain), and metoprolol tartrate 25 mg (cardiac). The prescription for clindamycin 300 mg was dated for 12/27/23. On 10/28/24 at 12:43 PM, the [NAME] President Clinical (VPC), in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Licensed Nursing Home Administrator (ALNHA), Regional Social Worker, Director of Nursing (DON), and survey team, stated that the resident was on two antibiotics; the Macrobid was completed but the clindamycin was supposed to continue. The VPC further stated that the resident should have been discharged with the clindamycin but was not because the Nurse Practitioner (NP) thought both antibiotics were completed, and she did not write a prescription for the clindamycin. The VPC also stated that it was a miscommunication and when the assisted living facility contacted the nursing home, a prescription for the clindamycin was sent to them. On 10/29/24 at 10:42 AM, the VPC in the presence of the LNHA, ALNHA, Regional Administrator, Regional Social Worker, DON, Assistant Director of Nursing (ADON), and survey team stated that the NP dropped the ball and missed the clindamycin when writing the prescriptions for discharge. The VPC acknowledged that the resident did not get their medication on time and there should have not been any missed doses of the clindamycin. A review of the facility's Discharge Summary and Plan with a revision date of January 2019, included when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to new changes in medication regimen related his/her new living environment. Medication therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident) . NJAC 8:39-27.1(a)

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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. 40744 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to develop an individualized comprehensive care plan for a resident with chronic pain. This deficient practice was identified for 1 of 1 resident reviewed for pain management (Resident #10), and was evidenced by the following: On 10/22/24 at 12:17 PM, during initial tour of the facility, the surveyor observed Resident #10 in bed with eyes closed. On 10/24/24 at 10:01 AM, the surveyor reviewed the medical record for Resident #10. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with medical diagnoses which included but were not limited to; diabetes (high blood sugar), depressive disorder, and chronic pain syndrome. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 9/15/24, revealed the resident had a Brief Interview of Mental Status score of 15 out of 15, meaning the resident was cognitively intact. A review of Section J Health Conditions revealed the resident had frequent pain and was receiving pain medications. A review of the active Order Summary Report revealed the resident was receiving pain medications. The resident had a physician's orders (PO) dated 9/14/23, for oxycodone (a narcotic pain reliever) 10 milligrams (mg); administer one tablet every four hours as needed for severe pain and a PO dated 9/14/23, for oxycodone 5 mg; administer one tablet every four hours as needed for moderate pain. A review of the corresponding October 2024 Medication Administration Record (MAR) revealed the resident received pain medication daily during the month of October. A review of the individual comprehensive care plan (ICCP) did not include a focus area for pain. On 10/24/24 at 12:24 PM, the surveyor observed Resident #10 in the hallway in a wheelchair. The resident was speaking with the Unit Manager/Licensed Practical Nurse (UM/LPN) of the B wing nursing unit. The resident told the UM/LPN that they needed an appointment related to shoulder pain. On 10/25/24 at 10:28 AM, the surveyor interviewed the UM/LPN regarding the resident and pain. The UM/LPN told the surveyor that the resident had neck and shoulder pain and was receiving pain medications. The surveyor asked if a resident with pain should have a pain included in their ICCP, and the UM/LPN responded absolutely. On 10/29/24 at 10:40 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Clinical (VPC), and the Director of Nursing (DON) regarding the pain care plan. The VPC stated that the care plan was now initiated and agreed the care plan should have been initiated when the resident began with the pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Care Plans, Comprehensive Person-Centered policy dated October 2022, included a comprehensive, person-centered care plan, that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and function needs is developed and implemented for each resident . NJAC 8:30-27.1(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40744 Complaint # NJ169671 Based on interviews and review of pertinent facility documents, it was determined that the facility failed to revise an individual comprehensive care plan for a resident with a history of falls while at the facility. This deficient practice was identified for 1 of 1 resident reviewed for falls (Resident #189), and was evidenced by the following: On 10/24/24 at 11:32 AM, the surveyor reviewed the closed medical record for Resident #189. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with medical diagnoses that included but were not limited to; heart failure, difficulty in walking, surgical aftercare, and muscle weakness. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 10/16/23, revealed the resident had a Brief Interview of Mental Status score of 10 out of 15, meaning the resident had moderate cognitive impairment. A review of the the incidents and accidents for Resident #189 revealed the resident had a fall on 12/4/23. The resident was found by a Certified Nursing Assistant (CNA) in the bathroom sitting on the floor. The resident informed the staff that they slid off their wheelchair, and the resident sustained no injuries. Included in the report was an interdisciplinary team note dated 12/5/24, that the team met to discuss the fall plan of care, and the new intervention of frequent bathroom rounds will be conducted to ensure safety was added. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 10/9/23, that the resident was at risk for falls with regards to gait/balance problems, anemia, atrial fibrillation (abnormal heart rhythm), hypertension (high blood pressure), deep vein thrombosis (formation of blood clots in deep veins), and venous insufficiency (veins have difficulty send blood from limbs back to heart). Interventions included to anticipate and meet the resident's needs; be sure the resident's call light is within reach and encourage the resident to use it for assistance; and physical therapy evaluate and treat as ordered and needed. The ICCP was not updated after the resident's fall on 12/4/23, to include new interventions post fall. On 10/29/24 at 10:40 AM, during an interview with the [NAME] President of Clinical (VPC), the surveyor asked what should take place after a resident had a fall. The VPC responded, that after a fall, the ICCP should be reviewed and updated with new interventions. A review of the facility's Falls and Fall Risk, Managing policy dated updated October 2019, included if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . NJAC 8:39-27.1(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40744 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure recommendations by the wound care consultant were implemented to prevent the worsening of a pressure ulcer. This practice was identified in 1 of 2 residents reviewed for pressure ulcers (Resident #13), and was evidenced by the following: On 10/22/24 at 11:12 AM, during the initial tour of the facility, the surveyor observed Resident #13 in bed. The resident told the surveyor that they had a sore that opened. At that time, the surveyor did not observe a low air mattress (a mattress designed to prevent and treat pressure wounds) pump on the bed. The surveyor asked the resident if they were on a low air mattress or a specialty mattress and the resident replied, No, I don't know what they are doing. On 10/24/24 at 12:10 PM, the resident was observed in bed with eyes closed. The surveyor did not observe a low air loss mattress on the resident's bed. On 10/25/24 at 9:35 AM, the surveyor reviewed the medical record for Resident #13. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with medical diagnoses which included but were not limited to; major depressive disorder, chronic pain, kidney stones, and cerebral infarction (when blood flow to the brain is blocked). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 9/4/24, revealed the resident had a Brief Interview of Mental Status score of 15 out of 15, meaning the resident was cognitively intact. A review of Section M. Skin Assessment revealed the resident had an unstageable pressure ulcer (full-thickness skin and tissue loss) with preventative measures which included a pressure relieving mattress. A review of the October 2024 Treatment Administration Record (TAR) included a physician's order dated 10/2/24, to cleanse pressure ulcer on left buttock with normal saline solution, pat dry, apply Medihoney (a honey dressing to treat wounds) and calcium alginate (used in wound dressings to promote healing); cover with gauze every day shift for wound care. A review of the wound consultation report dated 10/15/24, include the Wound Nurse Practitioner (WNP) saw the resident for a stage III pressure ulcer (full-thickness skin loss potentially extending into the subcutaneous tissue layer (deepest layer of skin)) to the left buttock. The WNP recommended for the treatment of the left buttock pressure ulcer, to offload pressure with a low air-loss (LAL) mattress with turning and positioning measures in place. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 4/26/23, and revised 8/22/24, that the resident had a pressure ulcer to the left buttock. Interventions included to teach the resident, family, and caregivers the importance of changing positions for prevention of pressure ulcers; encourage small frequent position changes; and follow facility policies and protocols for the prevention and treatment of skin breakdown. The ICCP did not include the use of a LAL mattress as recommended by the WNP. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the active Order Summary Report did not include a physician's order for a LAL mattress. On 10/25/24 at 10:05 AM, the surveyor interviewed Resident #13's Licensed Practical Nurse (LPN), who stated the resident had a stage three pressure ulcer and received wound care daily. The LPN stated that the resident was seen weekly for wound care consultations. The surveyor asked what preventative measures were in place for the resident, and the LPN stated the resident had an air (LAL) mattress. At that time, the surveyor accompanied by the LPN went to Resident #13's room, and the LPN confirmed the resident did not have a LAL mattress. On 10/25/24 at 10:11 AM, the surveyor observed the resident in bed receiving care from the Certified Nursing Assistant (CNA). At that time, the resident informed the surveyor that the nurse already did wound care for the day. The surveyor asked the resident if they were on an air (LAL) mattress, and the resident replied, No, but I need one. On 10/25/24 at 10:20 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) regarding the resident's wound, and the UM/LPN stated that the resident had a stage two pressure ulcer (partial thickness loss). The surveyor asked if the resident had an air (LAL) mattress and she stated I think so, but if not, maybe the resident refused. At that time the resident requested documentation of the resident's refusal. On 10/29/24 at 10:40 AM, during a meeting with the [NAME] President of Clinical (VPC), the surveyor asked about Resident #13's air (LAL) mattress. The VPC acknowledged the resident should have had the air (LAL) mattress prior to surveyor inquiry, and staff needed to be educated to follow wound care consultant recommendations. No additional information was provided. A review of the facility's Wound Care policy dated updated May 2023, did not include the process for wound care consultation recommendations and LAL mattresses. NJAC 8:39-27.1(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49094 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) ensure the accountability of the narcotic shift count logs were completed; and b.) accurately account for and document the administration of controlled medications. This deficient practice was identified on 2 of 2 medication carts reviewed for medication storage, and was evidenced by the following: During medication storage review on 10/24/24 at 10:39 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN #1), reviewed the Vent unit medication cart A's September and October 2024 Change of Shift - Controlled Substances Count Sheet (a shift-to-shift controlled substance and narcotics (narc) count sheet signed by the incoming and outgoing nurses each shift) which revealed the following: The nursing signatures were blank for the incoming nurse for the following shifts: For the 7:00 AM (7 AM) shift on: 9/14, 9/29, 10/4, 10/5, 10/6, 10/20, and 10/24. For the 7:00 PM (7 PM) shift on: 9/6, 10/1, 10/15, and 10/22. For the 11:00 PM (11 PM) shift on: 9/27 and 10/14. The nursing signatures were blank for the outgoing nurse for the following shifts: For the 7 AM shift on: 9/7, 10/15, 10/16, and 10/23. For the 7 PM shift on: 9/15, 9/29, 10/3, 10/4, 10/5, 10/6, and 10/20. For the 11:00 PM shift on: 9/27. The narcotic counts Count (Number of Cards) were blank for the following shifts: For the 7 AM shift on: 9/1, 9/4, 9/6, 9/10, 9/13, 9/14, 9/15, 9/16, 9/19, 9/20, 9/23, 9/25, 9/28, 10/4, 10/5, 10/6, 10/8, 10/9, 10/10, 10/20, 10/21, and 10/24. For the 3:00 PM (3 PM) shift on: 9/10. For the 7 PM shift on: 9/1, 9/4, 9/5, 9/6, 9/9, 9/14, 9/15, 9/16, 9/19, 9/20, 9/23, 9/25, 9/26, 10/3, 10/4, 10/5, 10/6, 10/8, 10/12, 10/17, 10/19, 10/20, and 10/21. For the 11:00 PM (11 PM) shift on: 9/12, 9/13, 9/27, 10/9, and 10/14. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the cart revealed the individual resident Controlled Drug Administration Record log (declining inventory log) for Resident #291 indicated the 9:00 AM (9 AM) dose of clonazepam (a controlled medication used to treat anxiety) 1 milligram (mg) tablet was not signed out on the declining inventory log. The declining inventory log was missing the [Administered] By signatures for the 10/24/24 at 9 AM dose. At the time of observation, the surveyor interviewed LPN #1, who stated she administered the 9 AM dose of clonazepam that morning but did not sign Resident #291's declining inventory log. LPN # 1 confirmed that the 9 AM dose was signed out as being administered in the electronic Medication Administration Record (MAR), but was not accounted for on the declining inventory log. LPN #1 further acknowledged that the declining inventory logs should be completed upon dispensing the medication to keep track of the narcotic count. LPN #1 also stated that shift-to-shift logs should be completed by two nurses at each shift change indicating narcotic count was completed and all narcotics were accounted for. LPN #1 stated that shift-to-shift counts were done for accountability of narcotics and there should not have been any missing documentation or signatures. LPN #1 further acknowledged that she forgot to sign the incoming nurse portion for this morning's shift change. During medication storage review on 10/24/24 at 11:35 AM, the surveyor in the presence of LPN #2, reviewed the A wing medication cart B's October 2024 Change of Shift - Controlled Substances Count Sheet which revealed the following: The narcotic counts Count (Number of Cards) were blank for the following shifts: For the 7 AM shift on: 10/22, 10/23, and 10/24. For the 3 PM shift on: 10/22. For the 11 PM shift on: 10/21, 10/22, and 10/23. At the time of observation, LPN #2 stated that she was not sure if the number of cards column should be filled out since there were a lot of blanks. LPN #2 further stated she was going to count the narcotics at the end of her shift and fill out the column then. She further acknowledged that there should be no missing count (number of cards) on the narcotic count sheets. LPN #2 then stated that shift-to-shift count was done for the accountability of the narcotics. On 10/24/24 at 12:21 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the shift-to-shift narcotic count log should have been completed by the incoming and outgoing nurses together at shift change. The nurses count the number of narcotic cards to ensure there was the correct number of narcotic cards and it matched the shift-to-shift narcotic count log. The DON stated there should be no missing documentation or signatures on the narcotic count logs because it was for accountability. The DON then stated the purpose of the shift-to-shift narcotic log was to keep track of the narcotic card counts. The DON further acknowledged that the declining inventory logs should be completed and filled out for each narcotic dose dispensed immediately at the time the medication was removed from inventory. The DON acknowledged that if it was not documented it was not done. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 10:39 AM, the [NAME] President of Clinical (VPC) in the presence of the DON, Licensed Nursing Home Administrator (LNHA), Regional Food Service Director, Food Service Director, and Assistant Licensed Nursing Home Administrator (ALNHA), acknowledged that the shift-to-shift count sheets were not completed. The VPC also stated that they did an in-service for all nurses and implemented a new shift to shift log. The VPC acknowledged that the shift-to-shift narcotic logs should have not have any missing signatures or counts. The VPC further acknowledged that when dispensing a narcotic, the nurse needed to sign the narcotic declining inventory log immediately. A review of the facility's Controlled Substance Administration & Accountability policy with a revision date February 2023, included . 1. All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must clearly legible with all applicable information provided. All specially compounded or non-stock Schedule II controlled substances dispensed from the pharmacy for a specific patient are recorded on the Controlled Drug Record supplied with the medication or other designated form as per facility policy. The Controlled Drug Record serves the dual purpose of recording both narcotic disposition and patient administration. The Controlled Drug Record is permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy. 6. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift . NJAC 8:39-29.7(c)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44833 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medications. This deficient practice was observed in 1 of 4 medication carts reviewed for medication storage and labeling, and was evidenced by the following: On 10/24/24 at 10:39 AM, the surveyor observed the Vent nursing unit's medication cart A. The medication cart was kept at the nurse's station and was left unattended by the Licensed Practical Nurse (LPN #1) while she administered medication to an unsampled resident. On the cart's unlockable pull-out tray/drawer, was observed packets of individually wrapped medications stored and visible with the tray/drawer in the retracted position. Upon return of LPN #1, the surveyor reviewed the cart and observed the following unsecured medications in the tray/drawer: One Eliquis 5 milligram (mg) tablet (tab) (medication used to prevent blood clots). Two midodrine HCl 5 mg tabs (medication used to treat low blood pressure). Two midodrine HCl 2.5 mg tab. One memantine HCl 10 mg tab (medication used to treat dementia). One pravastatin sodium 10 mg tab (medication used to treat high cholesterol). One oxybutynin chloride 5 mg tab (used to treat overactive bladder). One levofloxacin 500 mg tab (antibiotic). Two baclofen 10 mg tab (used to treat muscle spasms). Two 0.5 tabs of metoprolol tartrate 25 mg (used to treat high blood pressure). One amiodarone HCl 200 mg tab (used to treat heart disease). At that time, the surveyor interviewed LPN #1 who stated medication should not be left on that tray as that would not be considered secured. She further stated that there was a risk of someone coming by and taking them since they were unsecured. On 10/24/24 at 12:21 PM, the surveyor interviewed the Director of Nursing (DON) who stated medication should always be secured and locked, regardless of if residents on the unit were ambulatory or not. The DON further confirmed when presented with a photo of how the medications were observed, that those medications would not be considered secured and should not have been stored that way. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Bayshore LLC	715 North Beers Street Holmdel, NJ 07733

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 10:39 AM, the [NAME] President of Clinical (VPC), in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA), and DON, confirmed that medication should not have been stored unsecured on the medication cart and that all nurses were to keep medications secured. A review of the facility's Medication Storage policy with a reviewed date of 11/2022, included the facility shall store all medications and biologicals in a safe, secure, and orderly manner .all medications will be stored in locked cabinet, cart or medication room that is accessible only to authorized personnel . NJAC 8:39-29.4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. Building B. Wing	10/30/2024

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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 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. 45208 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain kitchen equipment in a clean and sanitary manner. This deficient practice has the potential to affect all residents, and the evidence was as follows: On 10/22/24 at 9:53 AM, the surveyor in the presence of the Food Service Director (FSD) and Regional Food Service Director (RFSD) toured the kitchen and observed the following: 1. The ice machine had stains, brown and tan debris on the outside and flap of the machine. The FSD stated, it should be cleaned daily. The FSD and RFSD both acknowledge that it looked dirty and was not cleaned. 2. There were two, thirty-two gallon waste receptacles that were not covered which exposed the two food preparation stations to the refuse. The stations were not actively being used. The RFSD acknowledged that the waste receptacles did not have lids and staff were not currently using them. The unlidded thirty-two-gallon waste receptacles at counter height had the potential for cross contamination of food. 3. The eight-burner stove with two catch drip trays, had large quantities of brown, black, and burnt food and yellowed sludge that was on the foil covering. The FSD and RFSD acknowledged that they had not been cleaned and staff were not following the facility policy. 4. The slicer that was covered with a clear plastic bag, had brown, dried, and crusted debris on the prong part of the pusher that was touching the gauge plate. The FSD stated that the clear plastic bag indicated the equipment was clean and ready for use. The FSD and RFSD acknowledged that the pusher was not clean and had potential for cross contamination of food and had the potential to cause a food borne illness. 5. The can opener base had black and brown crusted debris that was wipeable by the FSD. The FSD stated the can opener was cleaned daily and the base of the can opener was included in that cleaning assignment. The FSD acknowledged that the base was dirty and had not been cleaned. She further stated it could cause cross contamination and had the potential to cause food borne illness. 6. Two, six compartment open well steam tables that had hot water in each well. The water in every well had floating debris and debris that had settled on the bottom. The FSD stated it was cleaned daily. The surveyor asked if string beans were served for breakfast and the FSD acknowledged there were no string beans served and that the steam tables had not been cleaned according to facility policy. The FSD and RFSD both acknowledged that the dirty water and sediment had the potential for food borne illnesses. On 10/25/24 at 12:20 PM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON), and survey team acknowledged the concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. Building B. Wing	10/30/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the undated facility provided Equipment Cleaning Policy included the Director of Dining Services or designee will ensure that all equipment is maintained, kept clean, and in a sanitary condition before and after each use .2. Stove-top; a) clean stove top after each use .d) be sure to clean the grease tray .7. Slicer . b) take slicer apart. Using soap and water to clean it. c) let the slicer air dry before covering it .9. Steam Table; a) after each meal service, drain the water from the steam table. b) It must be cleaned after each use both inside and out using soap and water before you refill it with clean water .13. Can Opener; run the opener shaft through the dish machine or in the 3-compartment sink. b) Clean the base of the can opener and holder using soap and water . A review of the undated facility provided Ice Machines Sanitation policy included kitchen staff will wash, rinse, and sanitize the ice making machine monthly . A review of the undated facility provided Ice Machine Maintenance log included .outside of ice machine should be cleaned and sanitized daily . NJAC 8:39-17.2(g)