

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395359	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/14/2025
NAME OF PROVIDER OR SUPPLIER: JERSEY SHORE SKILLED NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1008 THOMPSON STREET JERSEY SHORE, PA 17740		
STATE LICENSE NUMBER: 121302				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0677 SS=D	Based on an Abbreviated Survey in response to four Complaint Investigations completed on August 14, 2025, it was determined that Jersey Shore Skilled Nursing and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.	F 0677		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0677 SS=D	Continued from page 1 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take actions set forth in the following plan of correction. 1. Residents #5 and #7 had no negative outcome from not receiving Activities of Daily Living (ADL) care. Once identified, ADL care was provided to both residents. 2. An initial audit will be conducted by the Director of Nursing\designee of facility residents who require ADL assistance to ensure completion of his\her ADL documentation for the past seven days to determine if there were residents with missed or not completed ADL care. Residents identified with missed or not completed ADL care will be assessed by a Registered Nurse and will ensure care is completed. 3. Education will be provided to facility nursing staff regarding the Nursing Policy Activities of Daily	Completion Date: 09/23/2025 Status: APPROVED Date: 08/26/2025

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F 0677 SS=D	Continued from page 2	F 0677	Living (ADLs) and nursing assistant shift responsibilities. 4. Audits will be conducted by the Director of Nursing\designee of ten random facility residents who require ADL assistance to ensure completion of his\her ADL documentation and care will be conducted weekly x four and then monthly x three by the facility Director of Nursing or designee(s). Corrections and\or care will be made as necessary and results of audits will be reported at the Quality Assurance Performance Improvement meetings.	

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F 0677 SS=D	Continued from page 3 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide activities of daily living care for dependent residents for two of 10 residents reviewed (Residents 5 and 7). Findings include: Interview with Resident 5 on August 14, 2025, at 10:21 AM revealed that no staff provided morning care assistance (e.g., bathing, hygiene, or incontinence care) on this date. Resident 5 stated, "they (staff) have done nothing since 4:00 this morning, six hours, no care, no one changed me." Clinical record review for Resident 5 revealed a significant change MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated July 25, 2025, that assessed Resident 5 as without cognitive deficits (BIMS, Brief Interview for Mental Status, score of 15 out of 15), frequently incontinent of urine and always incontinent of bowel, dependent on staff for toileting, and that he required substantial to maximum assistance with hygiene and bathing. Interview with Employee 1 (licensed practical nurse) on August 14, 2025, at 10:30 AM revealed that the unit had four nurse aides assigned at the beginning of the shift; however, one nurse aide (Employee 2, nurse aide) left the	F 0677		

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F 0677 SS=D	Continued from page 4 building to accompany a resident to a medical appointment. A nurse aide from the other hallway (Employee 6, nurse aide) was to assume the assignment for Employee 2. Employee 1 confirmed that, according to the assignment sheet she had Resident 5, and morning care was not completed. Interview with Employee 6 on August 14, 2025, at 10:35 AM confirmed that she had not provided Resident 5 any care yet on this date. Interview with Employee 3 (nurse aide) on August 14, 2025, at 10:42 AM confirmed that she was assigned to the hallway on which Resident 5 resided; however, she did not provide any care to Resident 5 on this date. Interview with Employee 5 (nurse aide) on August 14, 2025, at 11:10 AM confirmed that she was assigned to the nursing unit on which Resident 5 resided; however, she did not provide any care to Resident 5 on this date because she was working on the other hallway. Interview with Employee 2 (nurse aide) on August 14, 2025, at 2:25 PM (upon her return to the building) confirmed that she did not provide morning care to Resident 5 on this date. Employee 2 stated that she passed breakfast trays and then left the building with a resident for a medical appointment.	F 0677		

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F 0677 SS=D	Continued from page 5 Clinical record review for Resident 5 revealed Documentation Survey Report (electronic documentation by nurse aide staff to record care provided) data dated August 14, 2025, at 12:24 PM that indicated no staff noted the completion of care related to bathing, dressing, hygiene, or toileting for Resident 5 on this date. The Documentation Survey Report dated August 2025c, also indicated that staff noted hygiene assistance for Resident 5 was "Not Applicable (indicating care did not occur)," for day shift on August 5, 7, 8, and 10, 2025. The same document indicated that staff noted Toilet/Bladder/Bowel assistance for Resident 5 was "Not Applicable," for August day shift on August 1, 2, 3, 6, 7, 8, 11, and 12, 2025. The Documentation Survey Report dated July 2025, indicated that staff failed to provide hygiene assistance to Resident 5 on the following dates and shifts: July 1, 2025, day shift July 5, 2025, day shift and evening shift July 21, 2025, evening shift July 26, 2025, day shift July 27, 2025, day shift and evening shift The Documentation Survey Report dated July 2025, indicated that staff failed to provide toilet/bladder/bowel assistance to Resident 5 on the following dates and shifts:	F 0677		

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F 0677 SS=D	Continued from page 6 July 1, 2025, day shift and evening shift July 5, 2025, day shift July 9, 2025, evening shift July 10, 2025, day shift July 11, 2025, day shift July 12, 2025, evening shift July 14, 2025, day shift July 15, 2025, evening shift July 21, 2025, evening shift July 22, 23, 24, and 25, 2025, day shift July 27, 2025, evening shift July 30 and 31, 2025, day shift The surveyor reviewed the above concerns regarding Resident 5's activities of daily living care during an interview with the Nursing Home Administrator and the Director of Nursing on August 14, 2025, at 3:30 PM. Observation of Resident 7 on August 14, 2025, at 10:43 AM revealed she was in bed. Interview with Employee 3 on the date and time of the observation revealed that she just completed Resident 7's morning care. Employee 3 stated that skilled therapy staff would arrive on the unit before lunch and staff would transfer Resident 7 out of bed to leave the nursing unit at that time. Observation of the second-floor nursing unit on August 14, 2025, at 11:09 AM revealed staff transported Resident 7	F 0677		

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F 0677 SS=D	Continued from page 7 in a wheelchair onto the elevator to leave the nursing unit. Clinical record review for Resident 7 revealed a plan of care developed by the facility to address her activities of daily living self-care deficit (last revised June 1, 2022) that listed interventions that included: Transfer with mechanical full body lift Out of bed to geri (geriatric) lounge chair Assist with daily hygiene, grooming, dressing, oral care, and eating as needed Observation of Resident 7 on August 14, 2025, at 1:46 PM revealed she was in her wheelchair outside her room door. Interview with Employee 3 on August 14, 2025, at 1:48 PM revealed that Resident 7 was not transferred out of her wheelchair (via a total lift) or provided incontinence care since she provided her morning care (completed at 10:43 AM). Observation of Resident 7 on August 14, 2025, at 2:30 PM revealed that Employee 3 and Employee 2 transported Resident 7 into her room with a lift device to provide care. A plan of care developed by the facility to address Resident 7's incontinence of bowel and bladder (last revised April 1, 2019) revealed interventions that included to "See Task list for individualized toileting plan."	F 0677		

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F 0677 SS=D	Continued from page 8 Review of a Documentation Survey Report (Task list documentation) dated August 2025, for Resident 7 revealed the Intervention/Task of "Individual Toileting Plan: after breakfast and Lunch before super and after super, HS (hour of sleep/bedtime), all rounds on 11-7 (11:00 PM to 7:00 AM) and as needed," was initialed as completed by Employee 3 on August 14, 2025, at 2:59 PM although no staff assisted Resident 7 with toileting after lunch on this date. Resident 7 did not receive incontinence care for the almost four hours reviewed or incontinence care after lunch per her toileting program. The surveyor reviewed the above concerns regarding Resident 7's activities of daily living care during an interview with the Nursing Home Administrator and the Director of Nursing on August 14, 2025, at 3:30 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0677		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 9 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take actions set forth in the following plan of correction. 1. Residents #1 and #2 had the Enhanced Barrier Precaution signs corrected at the time of the survey. Residents #1, #2, and #3 had no negative outcome from EBP personal protective equipment not worn during the care that was provided during surveyor observation. 2. An initial audit will be conducted of residents that meet the Enhanced Barrier Precautions by the Director of Nursing\designee to ensure signage and personal protective equipment is in place. An initial audit of residents on EBP will be conducted to ensure staff on each shift are donning the appropriate PPE to complete the care he\she is providing. Corrections will be made as needed.	Completion Date: 09/23/2025 Status: APPROVED Date: 08/26/2025

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F 0880 SS=E	Continued from page 10 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	3. Education will be provided to the facility licensed nursing staff regarding facility procedure Enhanced Barrier Precautions. 4. Audits will be conducted weekly x four and monthly x three by the Director of Nursing\designee of residents that meet the Enhanced Barrier Precautions to ensure signage is in place. A random audit of five residents on EBP will be conducted by the Director of Nursing\designee weekly x four and monthly x three to ensure staff on each shift are donning the appropriate PPE to complete the care he\she is providing. Corrections will be made as needed. Results of audits will be reported at the Quality Assurance Performance Improvement meetings.	

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F 0880 SS=E	Continued from page 12 Based on a review of select facility policies and procedures, observation, clinical record review, and staff interview, it was determined that the facility failed to implement appropriate enhanced barrier precautions for three of four residents reviewed for infection control concerns (Residents 1, 2, and 3). Findings include: Review of the Center for Medicaid and Medicare Services (CMS) memo entitled, "Enhanced Barrier Precautions (EBP, gown and glove use) in Nursing Homes to Prevent the Spread of Multi-drug Resistant Organisms," released by CMS on March 20, 2024, with an implementation date of April 1, 2024, revealed that nursing care facilities are to use EBP for residents with chronic wounds or indwelling medical devices (e.g., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care. Review of the facility's current policy entitled "Enhanced Barrier Precautions," last revised December 16, 2024, revealed that EBP is defined as an infection control intervention designed to reduce the transmission of novel or multi-drug-resistant organisms (MDROs, bacteria and other microorganisms that have developed resistance to	F 0880		

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F 0880 SS=E	Continued from page 13 one or more classes of antimicrobial medications). It employs targeted personal protective equipment (PPE) use during high-contact resident activities. Use EBP for a resident with a wound or indwelling medical device. The policy referred to an "Enhanced Barrier Precautions procedure." Review of the facility's, "Procedure: Enhanced Barrier Precautions," revealed that the first step is for staff to post the appropriate EBP sign on the resident's room door. For all residents with a chronic wound and/or an indwelling medical device (e.g., urinary catheter) staff are required to use a gown and gloves prior to high-contact care activities which include: dressing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and device care. Clinical record review for Resident 3 revealed her diagnoses list included: Urinary tract infection (infection of any part of the urinary system such as the urethra, bladder, ureters, or kidneys) Neuromuscular Dysfunction of Bladder (neurogenic bladder, communication between the brain and bladder malfunctions and can cause retention of urine) Bacteremia (presence of bacteria in the blood) Pressure ulcer of the sacrum, Stage IV (wound with full-thickness skin and tissue loss over the area at the base of the spine)	F 0880		

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F 0880 SS=E	Continued from page 14 Active physician orders for Resident 3 included: Change Indwelling catheter when occluded or leaking as needed (dated August 8, 2025) Indwelling catheter 16FR (diameter size of tubing, size 16 French) with 10 ml (milliliters) balloon to bedside straight drainage for diagnosis of neuromuscular dysfunction of bladder (dated August 8, 2025) Wound: Negative Pressure Wound Therapy (wound vac, gentle suction applied to the wound bed to improve the wound environment and promote healing of complicated wounds) to buttocks. Cleanse with wound cleanser, place gauze/black into wound, apply skin prep (liquid protective skin barrier) to intact skin around the wound, and window tape the peri-wound (area around the wound) with a transparent dressing. Cover with occlusive transparent dressing and secure tubing per manufacturer guide every day shift every three day(s) for sacral wound and as needed for soilage or dislodgement (dated August 8, 2025) If wound vac malfunctions, stop the wound vac, remove the dressing, cleanse the area with wound cleanser, and apply a dry dressing. Notify the provider (dated August 8, 2025) Nursing documentation dated August 12, 2025, at 2:50 PM	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395359	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/14/2025	
NAME OF PROVIDER OR SUPPLIER: JERSEY SHORE SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 121302		STREET ADDRESS, CITY, STATE, ZIP CODE: 1008 THOMPSON STREET JERSEY SHORE, PA 17740		
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F 0880 SS=E	Continued from page 15 revealed that staff noted Resident 3 had a urinary catheter intact, and she had a pressure ulcer on her sacrum and coccyx (tailbone, triangular shaped bone at the end of the spine). Observation of Resident 3's room door on August 14, 2025, at 9:45 AM revealed an EBP sign that Bed C (Resident 3's bed assignment in the three-bed room) required EBP. Observation of the room revealed four individuals (three facility staff and one staff from the facility's contracted transport company) transferring Resident 3 from her bed to a wheelchair. None of the four individuals observed were wearing an isolation gown. The contracted transport company staff propelled Resident 3's wheelchair out of the room and the tubing and collection container of an indwelling urinary catheter was observed near Resident 3's lower legs and feet. Observation of Resident 3's room on August 14, 2025, at 2:04 PM revealed Employee 2 (nurse aide) with the facility's contracted transport company staff returned Resident 3 to her room. Employee 2, Employee 3 (nurse aide), and Employee 6 (nurse aide), donned gloves to begin transferring Resident 3 from the wheelchair to her bed. Resident 3's indwelling urinary catheter collection bag and tubing was visible. The staff requested additional assistance from Employee 1 (licensed practical nurse) to complete the transfer. Employee 1 donned gloves. None of the four individuals donned an isolation gown before	F 0880		

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F 0880 SS=E	<p>Continued from page 16</p> <p>transferring Resident 3 from her wheelchair to her bed. Employees 3 and 6 changed Resident 3's incontinence brief during the observation without donning an isolation gown.</p> <p>The surveyor reviewed the above concerns regarding EBP for Resident 3 during an interview with the Nursing Home Administrator and the Director of Nursing on August 14, 2025, at 3:30 PM.</p> <p>Clinical record review for Resident 2 revealed active physician orders for staff to complete a treatment to Resident 2's left lower leg daily in the evening and as needed for dislodgement.</p> <p>Observation of Resident 2's room door on August 14, 2025, at 9:51 AM revealed a sign for EBP; however, the sign indicated that only Bed C in the room (the resident closest to the window) required EBP. Resident 2 was assigned the first bed, Bed A, the bed closest to the door.</p> <p>Observation of Resident 2's left lower leg with Employee 1 on August 14, 2025, at 9:54 AM revealed that she had a dressing covering the middle of her left lower leg. Employee 1 confirmed that evening shift staff complete a dressing change to Resident 2's left lower leg daily.</p> <p>Observation of Resident 2 on August 14, 2025, at 1:38 PM revealed that she was yelling, and she wanted to get out of bed.</p>	F 0880		

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F 0880 SS=E	Continued from page 17 Observation of Employees 1 and 3 on August 14, 2025, at 1:48 PM revealed they donned gloves (but did not don an isolation gown) before changing Resident 2's incontinence brief and transferring Resident 2 from her bed to her wheelchair via a full-body mechanical lift. Once Resident 2 was in her wheelchair, Employee 1 completed a full linen change of her bed. Employee 1 was not wearing an isolation gown. Interview with Employee 1 on August 14, 2025, at 2:19 PM confirmed that the EBP sign on Resident 2's door did not indicate that EBP were necessary for Resident 2 although Resident 2 had a wound that required daily treatment. Employee 1 confirmed that the PPE used for Resident 2's care was limited to glove use, and staff did not utilize an isolation gown for her high-contact care (that included dressing, transferring, changing her incontinence brief, and changing her linens). The surveyor reviewed the above concerns regarding the implementation of EBP for Resident 2 during an interview with the Director of Nursing and the Nursing Home Administrator on August 14, 2025, at 3:30 PM. Clinical record review for Resident 1 revealed active physician orders for staff to provide care to: A right flank and left flank nephrostomy tube (thin, flexible	F 0880		

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F 0880 SS=E	Continued from page 18 tubing surgically inserted through the side and directly into the kidney for the purpose of draining urine) daily and as needed A left inner thigh wound every shift and as needed A sacral wound every shift and as needed Nursing documentation dated August 13, 2025, at 6:38 PM revealed that staff admitted Resident 1 to the facility, and she had nephrostomy tubes draining urine into bags at her bedside. Observation of Resident 1's room door on August 14, 2025, at 2:32 PM revealed an EBP sign that indicated the residents in the B and D beds required EBP. Resident 1 resided in the C bed (bed closest to the window on the right side of the room). Observation of the second-floor nursing unit on August 14, 2025, at 2:35 PM revealed that Employee 5 (nurse aide) attempted to assist Resident 1 to transfer from her wheelchair to her bed; however, Employee 5 did not don an isolation gown to assist Resident 1 to transfer. Interview with Employee 4 (licensed practical nurse) on August 14, 2025, at 2:39 PM confirmed that the sign on Resident 1's door did not indicate that she required EBP; however, she did due to the presence of nephrostomy tubes. Employee 4 obtained a marker and added, "Bed C," to the sign on Resident 1's room door.	F 0880		

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F 0880 SS=E	Continued from page 19 During continued observation of Resident 1's room on August 14, 2025, at 2:42 PM Employee 5 requested additional assistance from Employee 4 to transfer Resident 1 to her bed. Employee 4 entered the room, did not don an isolation gown, and with the extensive physical assistance of Employees 4 and 5 (neither wearing an isolation gown), Resident 1 transferred from her wheelchair to her bed. Interview with Employee 7 (registered nurse) on August 14, 2025, at 2:42 PM while observing the staff transfer Resident 1, confirmed that the staff did not don an isolation gown to perform the high-contact activity. Employee 7 indicated that she was not familiar with Resident 1 due to her recent admission; however, the facility's infection preventionist would want a resident with indwelling nephrostomy tubes to have EBP in place. The surveyor reviewed the above concerns regarding the implementation of EBP for Resident 1 during an interview with the Nursing Home Administrator and the Director of Nursing on August 14, 2025, at 3:30 PM. 483.80 Infection Control Previously cited deficiency 5/16/25 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0880		

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F 0880 SS=E	Continued from page 20	F 0880			

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P 5520	<p>Nursing services.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take actions set forth in the following plan of correction.</p> <ol style="list-style-type: none"> 1.The facility attempts to staff to meet state required hours of staff and ratios per current state regulations. There were no ill effects to any residents. 2.An active recruitment campaign is ongoing including sign on bonuses, shift differentials and employee referral bonuses. The facility utilizes staffing agencies to fill in shifts as needed. 3.The facility nursing home administrator or designee will review with the director of nursing the latest guidelines for staffing ratios. 4.The facility nursing home administrator and director of nursing will meet to review staffing sheets to ensure proper staffing ratios daily x 5, and then weekly x 4 with results to the facility Quality Assessment and Assurance Committee. 	<p>Completion Date: 09/23/2025</p> <p>Status: APPROVED</p> <p>Date: 08/26/2025</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395359	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/14/2025
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P 5520	Continued from page 1 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 15 residents during the overnight shift for one of the 21 days reviewed. Findings include: A review of nursing care hours provided by the facility dated from May 24 through 30, 2025; June 30 through July 6, 2025; and August 7 through 13, 2025; revealed the following: Overnight shift: May 25, 2025, census of 85 with 5.38 NAs, required 5.67 Interview with the Nursing Home Administrator on August 14, 2025, at 3:00 PM confirmed the above findings.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 2 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take actions set forth in the following plan of correction. 1.The facility attempts to staff to meet state required hours of staff and ratios per current state regulations. There were no ill effects to any residents. 2.An active recruitment campaign is ongoing including sign on bonuses, shift differentials and employee referral bonuses. The facility utilizes staffing agencies to fill in shifts as needed. 3.The facility nursing home administrator or designee will review with the director of nursing the latest guidelines for staffing ratios. 4.The facility nursing home administrator and director of nursing will meet to review staffing sheets to	Completion Date: 09/23/2025 Status: APPROVED Date: 08/26/2025

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395359	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/14/2025
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P 5530	Continued from page 3 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 25 residents during the day shift for one of the 21 days reviewed; and one LPN per 40 residents during the overnight shift for one of the 21 days reviewed. Findings include: A review of nursing care hours provided by the facility dated from May 24 through 30, 2025; June 30 through July 6, 2025; and August 7 through 13, 2025; revealed the following: Day shift: August 9, 2025, census of 80 with 3.19 LPNs, required 3.20 Overnight shift: August 9, 2025, census of 81 with 1.69 LPNs, required 2.03 Interview with the Nursing Home Administrator on August 14, 2025, at 3:00 PM confirmed the above findings.	P 5530	ensure proper staffing ratios daily x 5, and then weekly x 4 with results to the facility Quality Assessment and Assurance Committee.	



Certified End Page

JERSEY SHORE SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 121302

SURVEY EXIT DATE: 08/14/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY