STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seashore Gardens Living Center	22 West Jimmie Leeds Road Galloway Township, NJ 08205

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43308 Complaint NJ #: 168222 and 168566 Based on interview, record review, and review of facility documents, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 2 of 7 residents (Resident #104 and 251) reviewed for accidents. This deficient practice was evidenced by the following: 1. On 1/30/24 at 11:57 AM, during the initial tour, Resident #104 was not in his/her room. A staff member identified Resident #104 in the dayroom sitting in a high back wheelchair with a chair alarm in place. The surveyor reviewed the medical record for Resident #104. According to the Admission Record (AR), Resident #104 had diagnoses which included, but were not limited to, unspecified dementia with behavioral disturbance, hypertension (high blood pressure), and senile degeneration of brain (progressive decline in a person's ability to think and remember). A review of the quarterly MDS, dated [DATE], reflected the resident had a Brief Interview for Mental Status (BIMS) score of 99, which indicated a severe cognition impairment and the resident was unable to complete the interview. Further review of the MDS reflected the resident had a history of falls. A review of the Incident Case Report that was provided by the facility revealed the following: On 5/27/23 the resident had an unwitnessed fall and had visible redness noted to the forearm. On 5/28/23 the resident had an unwitnessed fall with no signs of injury or pain noted. On 8/7/23 the resident had an unwitnessed fall with no injuries or pain noted. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Further review of the quarterly MDS in Section J: Health Conditions under J1900, indicated the resident only had two (2) falls with no injury, and zero (0) with injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains, or any fall related injury that causes the resident to complain of pain. Further review of the MDS did not reflect the fall with injury. A review of the of Progress Note (PN) from 5/27/23, reflected the resident had an unwitnessed fall and upon assessment the nurse found a pale pink 10 centimeter (cm) long x 1 cm wide marking on the resident left forearm. On 2/6/24 at 11:19 AM, Regional Nurse #1 stated in the presence of the Licensed Nurse Home Administrator (LNHA), the Director of Nursing (DON), Regional Nurse #2, the Regional LNHA and the survey team that the 8/26/23 MDS for Resident #104 was coded inaccurately and acknowledged that one of the falls was missed and should have been documented. 41260 2. According to the AR, Resident #251 had diagnoses which included, but were not limited to, insomnia, muscle weakness, difficulty walking, lack of coordination, and unspecified fall. Review of the significant change in status MDS, dated [DATE], included in Section J: Health Conditions that the resident did not have any falls since the prior assessment. Review of the MDS list in the resident's Electronic Medical Record (EMR) included that the last MDS assessment prior to 11/06/23 was dated 09/12/23. Review of the care plan, revised 12/21/23, included, at risk for falls due to impaired and reduced physical mobility, diuretic use, anxiety, non-compliance with transfers. Review of a PN, dated 10/07/23 at 3:30 AM, revealed that the Certified Nursing Assistant (CNA) observed Resident #251 slide out of bed, and due to the resident requiring a maximum assistance of two staff members for transfers, was unable to prevent the incident. Further review of the progress note included that the resident sustained a skin tear to the left fifth toe. Review of a PN, dated 10/31/23 at 1:02 PM, revealed that Resident #251's family member observed the resident fall in his/her room. Further review of the PN included that the resident did not have any injuries from the fall. During an interview with the surveyor on 02/05/24 at 12:46 PM, the MDS Coordinator (MDSC) stated she reviews nursing documentation from the EMR to complete the MDS assessments. The MDSC further stated that she reviews the Risk Management section in the EMR which lists all the falls in the previous three months in order to determine if the resident has had any falls since the prior MDS assessment. When asked how falls are captured on the MDS assessment, the MDSC stated that falls are coded three ways - if the resident had no injury, if the resident had a minor injury, and if the resident had a major injury. The MDSC and the surveyor then reviewed Resident #251's MDS assessments. The MDSC then verified that one fall without injury and one fall with minor injury should have been captured on the resident's 11/06/23 MDS assessment. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview with the surveyor on 02/06/24 at 11:30 AM, the Director of Nursing (DON) stated that the MDSC was responsible for completing the MDS assessments. The DON further stated that she would expect the MDSC to complete the MDS assessments accurately. When informed of Resident #251's 11/06/23 MDS assessment, the DON stated that the two falls should have been captured. Review of the Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023s, included instructions for Section J: Health Conditions. According to the manual, staff are to, Review all available sources for any fall since the last assessment, and, review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury. The manual further includes to Determine the number of falls that occurred since admission/entry or reentry or prior assessment and code the level of fall-related injury for each. NJAC 8:39-11.1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41260 Based on interview, record review, and review of facility documents, it was determined that the facility failed to develop a person-centered comprehensive care plan to include residents' a.) preference for activities and b.) risk for pain. This deficient practice was identified for 1 of 1 resident (Resident #253) reviewed for activities and for 2 of 2 residents (Resident #145 and #301) reviewed for pain management and was evidenced by the following: 1. On 01/30/24 at 10:39 AM, the surveyor observed Resident #253 sitting in a wheelchair in his/her room. The resident stated that he/she would like to go to activities, but that there is no one to take him/her. According to the Admission Record, Resident #253 had diagnoses which included, but were not limited to, unspecified hearing loss, muscle weakness, and altered mental status. Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated, 01/10/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident's cognition was moderately impaired. Further review of the MDS included it was very important to the resident to do things with groups of people, and, participate in religious services or practices. Review of the Recreation Assessment, dated 01/11/24, included, religion is important to [Resident #253] and [he/she] expressed interest in receiving Communion and religious visits. Review of the care plan, initiated 01/04/24, did not include the resident's preferences for activities or interventions to ensure the resident's activity preferences were met. During an interview with the surveyor on 02/01/24 at 11:52 AM, the Activities Director (AD) stated that the activities staff complete an initial assessment when residents are admitted to determine their activity preferences. During an interview with the surveyor on 02/01/24 at 12:10 PM, the Assistant Activities Director (AAD) stated that every resident was assessed for activity preferences upon admission to the facility. The AAD further stated she completed the Resident #253's Recreation Assessment, and that the resident was religious and Communion was available for the resident to attend. During a follow-up interview with the surveyor on 02/06/24 at 9:32 AM, the AD stated that the assigned activities staff member will document a resident's Recreation Assessment in the Electronic Medical Record (EMR) and then initiate a care plan related to the resident's preferences. The AD further stated that the activities staff who completed Resident #253's Recreation Assessment should have included the resident's activity preferences in the resident's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 02/06/24 at 11:30 AM, the Director of Nursing (DON) stated that resident care plans are initiated upon admission and should include resident preferences. The DON further explained that care plans include the resident's needs in order to develop a plan of care with appropriate interventions. When asked about Resident #253, the DON stated the care plan should have included the resident's activity preferences. 2. On 01/30/24 at 10:26 AM, the surveyor observed Resident #145 lying in bed. The resident complained of abdominal pain and stated he/she reported it to the facility staff. On 02/02/24 at 10:53 AM, the surveyor observed Resident #145 sitting in a wheelchair in his/her room. The resident stated that he/she had been receiving medication from the nurse that had helped with the abdominal pain. The resident also stated that he/she had an ultrasound of the abdomen and was waiting for the results. According to the Admission Record, Resident #145 was admitted with diagnoses which included, but were not limited to, calculus of kidney (kidney stone), unspecified abdominal pain, hydronephrosis (kidney swelling), and cirrhosis of liver (liver damage). Review of the admission MDS, dated [DATE], included the resident had a BIMS score of 13, which indicated the resident's cognition was intact. Review of the Order Summary Report, as of 02/05/24, included an order for an ultrasound of the abdomen, dated 01/30/24. Further review of the Order Summary Report included an order for Mylanta Maximum Strength Oral Suspension give 30 milliliters by mouth every 6 hours as needed for stomach upset and heartburn, ordered 01/29/24, and Carafate 1 gram give one tablet by mouth four times a day for stomach pain, ordered 01/30/24. Review of the Physician Note, dated 11/26/23, included, under assessment/plan, belly pain. Review of the Physicians Progress Note, dated 01/31/24, included Resident #145 complains of belly pain. Review of the Physicians Progress Note, dated 02/03/24, included Resident #145 complains of belly pain, and, Ascites [fluid collecting in the abdomen] with renal cyst on US [ultrasound], will add Aldactone [a diuretic] 25 mg [milligram] daily. Review of the care plan, initiated 12/19/23, did not include the resident's risk for pain or pain management interventions. During an interview with the surveyor on 02/05/24 at 11:00 AM, the Licensed Practical Nurse (LPN) stated that care plans are initiated upon admission and includes resident treatments. The LPN further stated that care plans inform the staff about the care required for the resident. When asked about Resident #145, the LPN stated the resident complained of abdominal pain, and the physician ordered Carafate and an abdominal ultrasound. The LPN then stated that since the resident was admitted with a diagnosis of abdominal pain and received treatment for the pain, the resident's pain management should have been included on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 02/05/24 at 11:50 AM, the LPN/Unit Manager (LPN/UM) stated each department is responsible for updating the resident care plans and that care plans should include anything the resident requires interventions for. The LPN/UM further stated that care plans benefit the resident because staff can refer to them for the appropriate interventions. When asked about Resident #145, the LPN/UM stated the resident complained of abdominal pain and the physician ordered an abdominal ultrasound and medication to help with the pain. At that time, the LPN/UM checked the resident's care plan and acknowledged that it did not include the resident's abdominal pain. The LPN/UM further stated she was unsure if the abdominal pain should be included on the care plan, but that it can be added on and probably will be. During an interview with the surveyor on 02/05/24 at 9:10 AM, the MDS Coordinator (MDSC) stated UMs are responsible for initiating and updating the resident care plans which includes any ongoing problems or risks for problems the resident has. The MDSC explained that care plans should be initiated within 24-72 hours and be updated as soon as there are nay new changes to the resident's treatment. The MDSC further stated that the purpose of care plans were to be able to give proper care to the resident, prevent deterioration, and to refer to any special services. When asked about Resident #145, the MDSC stated the resident's diagnosis of abdominal pain and the facility's management of that pain should have been included on the care plan. During an interview with the surveyor on 02/06/24 at 11:30 AM, the Director of Nursing (DON) stated that resident care plans are initiated upon admission and should include the resident's diagnoses. The DON further explained that care plans include the resident's needs in order to develop a plan of care with appropriate interventions. When asked about Resident #145, the DON stated the resident's pain management should have been included on the care plan. 43307 3. On 01/30/24 at 11:56 AM, Resident #301 was observed in bed, restless and groaning. There was a private duty caregiver at the resident's bedside who stated that she was a live-in caregiver (LIC). The LIC stated that the resident fell at home and broke their leg and had gotten pain medication when needed. On 02/02/24 at 11:52 AM, Resident #301 was observed in a wheelchair accompanied by their son. The surveyor inquired with the son as to whether the resident was having pain and the son stated, not now and stated that he/she would have made it verbally known if they had pain. According to the Admission Record, Resident #301 had diagnoses which included, but were not limited to, Alzheimer's disease, unspecified fracture of shaft of left femur, fracture of superior rim of left pubis, and osteoarthritis of knee. Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated, 01/29/24, included the resident had a Brief Interview for Mental Status score of 99 which indicated that the resident was unable to complete the interview. Review of the Care Plan (CP), initiated 01/22/24, did not include a resident's Focus for Pain. Review of the Order Summary Report, dated Active orders as of 02/06/24, revealed and order for Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for mild pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record, dated 01/01/2024-01/31/2024, revealed Resident #301 received pain medication on 01/23/24 at 0712 and again on 01/24/24 at 0713. During an interview with the surveyor on 02/02/24 at 12:05 PM, the Certified Nursing Assistant (CNA) who was caring for Resident #301, stated that she would ask the resident if he/she had pain and they would respond by stating, ouch. The CNA stated that if the resident had pain that she would tell the nurse and she would also make sure the resident did not seem to be in distress. During an interview with the surveyor on 02/05/24 at 11:03 AM, LPN #2 stated that a CP included interventions used for the residents as a part of their care. LPN #2 further stated that if a resident had pain that she would have expected to see pain management interventions on the CP. During an interview with the surveyor on 02/05/24 at 11:25 AM, the Licensed Practical Nurse Unit Manager (LPN/UM #2) stated that she would have expected to see a Focus of pain on a CP for a resident that had fractures with the interventions to choose from. She stated that there was a pain template that could have been modified for a resident. During an interview with the surveyor on 02/06/24 at 10:49 AM, the Director of Rehabilitation (DOR) stated that a CP was a snapshot of a resident and their needs and that every discipline was able to add to the CP their perspective from their discipline. The DOR stated that unless a resident complained of pain that she would not have expected to see a Focus of pain on the CP. The surveyor and the DOR reviewed Resident #301's CP together in the EMR and the DOR acknowledged that she did not see a focus of pain on the CP. During an interview with the surveyor on 02/06/24 at 11:47 AM, the surveyor and LPN #2 reviewed Resident #301's CP together in the EMR and LPN #2 acknowledged that she did not see a Focus of pain on the CP and that she would have expected to have seen it. LPN #2 stated that it was important to include pain on the CP because the interventions and goals were specific for each resident. During an interview with the surveyor on 02/06/24 at 11:56 AM, the surveyor and LPN/UM #2 reviewed Resident #301's CP together in the EMR and LPN/UM #2 acknowledged that she did not see a Focus of pain on the CP. She stated that if a resident was in pain, that pain should have been on the CP and that it was important that the pain was addressed. LPN/UM #2 then stated, I will put it in now. During an interview with the surveyor on 02/06/24 at 12:11 PM, the Assistant Director of Nursing (ADON) stated that if a resident had a femur and pelvic fractures that she would have expected to see pain on the CP. The surveyor and the ADON reviewed Resident #301's CP together in the EMR and the ADON was made aware that the Focus Pain was added by LPN/UM #2 after surveyor inquiry. During an interview with the surveyor on 02/06/24 at 12:19 PM, the DON stated that if a resident had a femur and pelvic fractures that she would have expected to see pain on the CP. The surveyor and the DON reviewed Resident #301's CP together in the EMR and the DON was made aware that the Focus Pain was added by LPN/UM #2 after surveyor inquiry. During an interview with the surveyor on 02/06/24 at 12:27 PM, the MDSC acknowledged that if a resident had a diagnosis of femur and pelvic fractures that she would have expected to see pain on the CP. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/24 at 03:39 PM, the surveyors met with the administration team and the surveyor discussed concerns about Resident #301's pain not being addressed on a CP and that it was added after surveyor inquiry. On 02/07/24 at 11:19 AM, the surveyors met with the administration team and the Regional Nurse (RN) stated that a full house pain CP audit was completed and that every resident that had a pain assessment with a pain CP, and in-services were completed. Review of the facility's Comprehensive Care Plans policy, undated, included, 1. The care planning process will include an assessment of the resident's strengths and needs .2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment . Other factors identified by the interdisciplinary team, or in accordance with resident's preferences, will also be addressed in the plan of care, and, The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being .f. Resident specific interventions that reflect the resident's needs . Review of the facility's Pain Assessment and Management policy, revised October 2022, included, Defining Goals and Appropriate Interventions. 1. The pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan. NJAC8:39-11.2 (e)(f)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 41260 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to provide a resident with meaningful activities that reflected the resident's preferences for 1 of 1 resident (Resident #253) reviewed for activities. This deficient practice was evidenced by the following: On 01/30/24 at 10:39 AM, the surveyor observed Resident #253 sitting in a wheelchair in his/her room. The resident stated that he/she would like to go to activities, but that there is no one to take him/her. On 02/01/24 at 9:45 AM, the surveyor sat in the lounge outside of Resident #253's room. There was an Activities Calendar on the table in the lounge that included a 10:00 AM sing-along activity. The calendar did not indicate where the activity was located. At 10:15 AM, the surveyor did not observe any sing-along activities on the unit, and staff did not enter the resident's room to offer to take her to an activity. Further review of the Activities Calendar included a 10:45 AM Communion activity. At 10:49 AM, the surveyor was still seated in the lounge and did not observe any Communion activity on the unit or staff offering to take the resident to the activity. At 10:51 AM, the surveyor observed a visitor enter the resident's room. When the surveyor entered the resident's room, the visitor identified him/herself as the resident's family member. When asked if the resident was offered to attend the sing-along or the Communion, the resident's family member asked the resident who stated, no. The resident's family member further stated that those would have been activities the resident would have attended. According to the Admission Record, Resident #253 had diagnoses which included, but were not limited to, unspecified hearing loss, muscle weakness, and altered mental status. Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated, 01/10/24, included the resident had a Brief Interview for Mental Status score of 10 which indicated the resident's cognition was moderately impaired. Further review of the MDS included it was very important to the resident to do things with groups of people, and, participate in religious services or practices. Review of the Recreation Assessment, dated 01/11/24, included, religion is important to [Resident #253] and [he/she] expressed interest in receiving Communion and religious visits. Review of the care plan, initiated 01/04/24, included the resident had a communication problem r/t [related to] hearing deficit, with an intervention that staff will anticipate and meet needs. The care plan did not include the resident's preferences for activities or interventions to ensure the resident's activity preferences are met. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 02/01/24 at 10:55 AM, the Certified Nursing Assistant (CNA) stated that there were no activities offered on the first floor subacute unit and that the calendar posted indicated the activities offered on the second floor units. The CNA further stated that if a resident needed assistance getting to and from an activity, the activities staff would assist the resident. The CNA added that it was important for residents to attend activities to prevent boredom and provide socialization. When asked about Resident #253, the CNA stated the resident does not attend activities. During an interview with the surveyor on 02/01/24 at 11:00 AM, the Licensed Practical Nurse (LPN) stated there were no specific activities on the subacute unit and if residents needed help going to and from an activity, the resident should have notified the staff. The LPN further stated that activities were important so that residents felt more at home. When asked about Resident #253, the LPN stated that he/she attends physical therapy, and the nursing staff place him/her in the lounge to watch television. During an interview with the surveyor on 02/01/24 at 11:08 AM, the LPN/Unit Manager (LPN/UM) stated that the activities calendar posted on the subacute unit informs the residents of activities available on the second floor and that if residents needed assistance getting to and from the activity, the nursing or activity staff would assist the resident. The LPN further stated that activities were important because they provided stimulation, distraction, and socialization. When asked about Resident #253, the LPN stated the resident required moderate assistance with activities of daily living and that staff could have assisted the resident with going to activities. During an interview with the surveyor on 02/01/24 at 11:52 AM, the Activities Director (AD) stated that the activities staff completed an initial assessment when residents were admitted to determine their activity preferences. During an interview with the surveyor on 02/01/24 at 12:10 PM, the Assistant Activities Director (AAD) stated that every resident was assessed for activity preferences upon admission to the facility. The AAD further stated she completed the resident's Recreation Assessment, and that Resident #253 was religious and Communion was available for the resident to attend. The AAD also stated she was unsure if staff assisted the resident with attending activities, but that staff should have offered to take the resident to activities as long as there were no schedule conflicts with physical therapy. During an interview with the surveyor on 02/06/24 at 11:30 AM, the Director of Nursing (DON) stated upon admission, the activities staff assess the resident to determine what activities the resident enjoys. The DON further stated that residents on the subacute unit have to attend activities on separate units. The DON added that nursing or activities staff will assist residents to and from the activities if needed and that activities are important for the residents' psychosocial wellbeing. When informed about Resident #253 missing activities that he/she would have liked to participate in, the DON stated that the CNAs on the unit are familiar with the resident's routine and should have taken him/her to the activities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated Activities policy, included, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Further review of the policy included, All staff will assist residents to and from activities when necessary. NJAC 8:39-7.3(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. 43308 Complaint #NJ168566 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to a.) ensure a pressure reducing device was used correctly and b.) failed to provide care and services consistent with professional standards of practice to promote the prevention of pressure ulcer/injury development specifically by not providing protective boots to heels as ordered. This deficient practice was identified for two (2) of four (4) residents (Resident #3 and #104) reviewed for pressure ulcer management. This deficient practice was evidenced by the following: 1. On 1/30/24 at 11:57 AM, during the initial tour, Resident #104 was not in their room. A staff member identified Resident #104 in the dayroom, sitting in a high back wheelchair, with a chair alarm on the back of the wheelchair. The surveyor reviewed the medical record for Resident #104. According to the Admission Record (AR), Resident #104 had diagnoses which included: unspecified dementia with behavioral disturbance, hypertension (high blood pressure), and senile degeneration of brain (progressive decline in a person's ability to think and remember). A review the annual Minimum Data Set (MDS), an assessment tool, dated 11/25/23, reflected the Brief Interview for Mental Status (BIMS) score was left blank as it indicated in section C0100 it was not conducted due to the resident rarely/never understood. A review in Section H - Bladder and Bowel indicated the resident was frequently incontinent. A review in Section M - Skin condition revealed the resident was at risk for developing pressure ulcers/injuries. A further review indicated the resident did not have one or more unhealed pressure ulcers/injuries. A review of the individualized comprehensive care plan (ICCP) included a focus area, dated 9/11/23, for I am at risk for skin breakdown r/t [related to] dementia. Interventions included to assess for changes in skin condition each shift, change bedding as needed, complete skin risk assessment as per facility policy, keep skin clean and dry, low air loss mattress, monitor skin care daily, provide incontinence care prn [as needed], and provide protective/preventative skin care. A review of the skin assessments from 09/25/23 to 02/06/24, indicated that the resident's skin was intact. On 02/01/24 at 10:24 AM, the surveyor observed Resident #104 in the dayroom sitting in a high back wheelchair. At that time, the surveyor observed the resident seated on a pressure reducing device, which was a black cushion covered with a white towel, that was directly underneath the resident. (continued on next page)

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	315340	A. Building B. Wing	02/08/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/01/24 at 01:04 PM, the surveyor observed Resident #104 in the dayroom sitting in a high back wheelchair. At that time, the surveyor observed the resident was still seated on top of the white towel covered black cushion that was directly underneath the resident. On 02/02/24 at 10:41 AM, the surveyor observed Resident #104 in the dayroom sitting in a high back wheelchair. At that time, the surveyor observed the resident seated on a white towel covered black cushion that was directly underneath the resident. On 02/05/24 at 10:28 AM, the surveyor observed Resident #104 in the dayroom sitting in a high back wheelchair. At that time, the surveyor observed the resident seated on a white blanket covered black cushion that was directly underneath the resident. On 02/05/24 at 10:29 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that she rounded on her residents every 2 hours and more frequently if needed. CNA #1 stated that most of the residents sat in the dayroom/dining room so staff would monitor the residents on the comfort care (dementia) unit. When asked if she placed anything underneath the residents while they were sitting in the chairs? CNA #1 stated that she did not personally put anything underneath her residents unless the resident was in the bed then she would put a blue chuck (pad) underneath the resident. CNA #1 then stated that if you put something underneath the resident it could damage their skin. She further stated that she felt that some CNAs placed towels underneath residents because it was a way of being lazy, so they did not have to toilet the resident frequently. CNA #1 then stated that the towel could have been used to prevent the resident from sliding and slipping out of their chair. She concluded that instead of putting a towel or blanket underneath a resident they could have gotten another cushion to prevent residents from sliding. On 02/05/24 at 10:35 AM, the surveyor interviewed CNA #2 who stated that she was caring for Resident #104 today (2/5/24). CNA #2 stated that she rounded on her residents when she first came in, after breakfast and then frequently throughout the day. She stated that the staff was very helpful and assisted her if she needed anything, because she was from an agency. When asked if she would put anything underneath the resident for those that needed to be toileted more frequently, CNA #2 stated that sometimes she would put a bath blanket underneath the resident but not a towel because the bath blanket was softer. She further stated that some cushions were plastic and the bath blanket was a barrier for comfort. CNA #2 emphasized that it was not to absorb anything but more of a cushion and comfort for the resident. She explained that a towel should not be underneath the resident because if a resident was sitting on it for a long period of time it could cause skin irritation and the goal was to prevent skin breakdown. CNA #2 stated that most of the resident's skin were fragile, and that staff needed to be mindful and ensure the resident was comfortable. CNA #2 stated that Resident #104 was on hospice and that the hospice aide came and provide morning care, dressed the resident, assisted with breakfast, and placed the resident in the wheelchair this morning. (continued on next page)

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	315340	A. Building B. Wing	02/08/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/24 at 10:55 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that staff rounded on the resident every hour. She further stated that if a resident needed to be toileted more frequently then they ensured that the resident was toileted more often. When asked if they would put anything underneath the resident, LPN #1 stated that they did not put anything underneath the resident because if they allowed urine to soak if could cause skin break down. She explained if the resident had a cushion seat, then they still should not place anything on top of the cushion directly underneath the resident because it could have caused skin breakdown. LPN #1 stated that Resident #104 was incontinent and currently did not have any wounds or skin breakdown. At that time, the surveyor and LPN #1 walked over to Resident #104 sitting in their high back wheelchair. LPN #1 confirmed Resident #104 was sitting directly on a white blanket that was placed on top of the black cushion. She acknowledged the resident should not have been sitting on the blanket. LPN #1 stated that the hospice aide got the resident up in the morning but that if someone had seen the blanket that they should have removed it. LPN #1 concluded they should remove the blanket to prevent skin breakdown. On 02/05/24 at 11:04 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) for the comfort care unit who stated that the residents in wheelchairs were provided seat cushions which helped prevent skin breakdown. The LPN/UM stated that the therapy department provided a blue gel pad that was placed underneath the seat cushion to prevent the resident from sliding. When asked if they placed anything on top of the cushion the LPN/UM stated that the resident should not have anything like a towel or blanket directly underneath them. She explained that the towels could have slid and it would not be conducive for the residents skin integrity. At that time, the surveyor and the LPN/UM walked over to Resident #104. The LPN/UM confirmed the resident was sitting directly on a white blanket that was placed on top of the black cushion. She then stated that the resident should not have had the blanket directly underneath them as it was not normal procedure. On 02/05/24 at 11:11 AM, the surveyor observed staff remove the blanket from underneath Resident #104. On 02/05/24 at 11:42 AM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The DON stated that the unit managers, the nurses, and the CNAs should round on their residents as soon as they started their shift. She further stated that the CNAs should have rounded on their residents at least every 2 hours and more often as needed. When asked if the staff needed to put anything underneath the resident that needed to be toileted frequently the DON stated it was very rare if you see the staff placing the chucks underneath the resident, which was used on the beds to prevent anything penetrating the sheets. The DON then stated that sometimes the staff used a towel or blanket to prevent residents from sliding. The DON then acknowledged they should not be placing a towel or blanket directly underneath the resident. At that time, the LNHA confirmed that staff should not have a towel of blanket on top of the cushion and should not be underneath as a barrier for residents that were incontinent. The LNHA then stated that a towel or blanket should only be placed underneath a resident if the resident or resident's representative requested it, and it was care planned for it. The LNHA acknowledged that the towel and blanket should not have been directly underneath the resident because it could have compromised the resident's skin integrity. On 02/05/24 at 12:05 PM, the LNHA stated in the presence of the survey team that she went to the comfort care unit and the LPN/UM informed her that it was the hospice aide that had placed the blanket underneath the resident because she thought to make the resident more comfortable. (continued on next page)

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	315340	A. Building B. Wing	02/08/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/07/24 at 09:49 AM, the surveyor interviewed the Director of Rehab (DOR) who stated that every resident with a wheelchair had the blue gel pad placed directly underneath the cushion to prevent the resident from sliding out of the chair. The DOR stated that the purpose of the cushion was for additional support, to prevent any skin breakdown, wounds and for comfort. She stated that there should not have been a towel or blanket on top of the cushion because the resident could have slid, and it was not supportive. The DOR emphasized another layer should not have been between the resident and the cushion. She then stated that some residents do request it, but they should be care planned as a preference. On 02/07/24 at 11:27 AM, Regional Nurse #1 stated in the presence of the Licensed Nurse Home Administrator (LNHA), the Director of Nursing (DON), Regional Nurse #2, the Regional LNHA and the survey team that items such as a towel and blanket should not be placed directly underneath the resident because it increased the risk for falls and skin integrity issues. She further stated that you are not getting the benefit of the cushion if you are putting something on top of the cushion. 43936 b.) On 02/01/2024 at 10:01 AM, the surveyor observed Resident # 3 in his/her room. At that time, Resident # 3 did not have protective heel boots on. During this time, he/she said they do not get protective heel boots put on him/her. On 02/05/2024 at 10:48 AM, the surveyor observed Resident # 3 in his/her room. At that time, Resident # 3 did not have protective heel boots on. On 02/05/2024 at 11:16 AM during an interview with the surveyor, Licensed Practical Nurse #2 confirmed an order for protective heel boots appeared in the orders in the Electronic Medical Record (EMR). On the same date at 11:20 AM, during an interview with the surveyor, CNA # 3 assigned to Resident # 3 said that protective heel boots were not in Resident # 3's room. On the same date at 11:37 AM, during an interview with the surveyor while in Resident # 3's room, the Registered Nurse/Unit Manager (RN/UM # 1) observed that the resident did not have protective heel boots on. At that time, RN/UM # 1 stated that the order could have been transcribed improperly. She concluded by saying she will make sure it appeared on the nurse's end. On 02/06/2024 at 4:00 PM during an interview with the surveyor, the Director of Nursing (DON) replied, Yes when asked by the surveyor if a resident had an order for protective heel boots to be worn while in bed every shift, should they have been placed on the resident's heels while they were in bed. The DON concluded by replying, Effects the skin integrity when asked by the surveyor what potential results could have occurred if the protective heel boots were not worn according to the order. A review of the EMR for Resident # 3 revealed a physician's order for protective boots to heels for every shift that was revised on 11/11/2023 and discontinued on 02/05/2024 at 11:24 AM. A review of the paper-chart for Resident # 3 revealed a telephone order sheet dated 11/11/2023 that revealed, Protective boots to heels. An initial and hand-written statement revealed, Noted 11/11/23 adjacent to the order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. Building B. Wing	02/08/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy Pressure Injury Prevention and Management revised 7/25/22, included, 4. Interventions for Prevention and to promote healing c.i. Redistribute pressure (such as repositioning, protecting and or offloading heels, etc.), iii. Provide appropriate, pressure re-distributing, support surfaces, iv. Provide non-irritating surfaces. N.J.A.C. S 8:39-27.1 (a)

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	315340	A. Building B. Wing	02/08/2024

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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. 43936 Complaint #NJ168222 and NJ168566 Based on observation, interview, and record review it was determined that the facility failed to ensure an environment was free from accident hazards by failing to place assistive devices, specifically bilateral floor mats, to prevent avoidable accidents for 1 of 7 residents (Resident # 97) investigated for Accidents. The deficient practice was evidenced by the following: On 01/30/2024 at 10:55 AM, during the initial tour of the facility, the surveyor observed Resident # 97 in their room in bed. The surveyor observed two blue floor mats folded and leaning against the wall on either side of the room. At that time, Resident # 97 replied, They haven't used them. when the surveyor asked if the facility had used the floor mats while he/she was in bed. On 02/05/2024 at 09:46 AM, the surveyor observed Resident # 97 in their room in bed. The surveyor observed the two blue floor mats folded and leaning against the wall on either side of the room. At that time, Resident # 97 replied, No when the surveyor asked if the facility had used the floor mats while he/she was in bed. A review of Resident # 97's Minimum Data Set (an assessment tool) dated 07/17/2023, revealed under section J that he/she had a fall in the last month prior to admission. A review of Resident # 97's Electronic Medical Record (EMR) revealed under Orders, a physician's order for bilateral floor mats beside bed while in bed every shift. The order was started on 08/30/2023. A review of Resident # 97's EMR revealed under Care Plan a focus for risk of falls related to impaired balance and mobility. The focus revealed an initiated date of 09/08/2023. The care plan revealed an intervention for bilateral floor mats at bedside. The intervention revealed an initiated date of 09/25/2023. On 02/05/2024 at 09:54 AM, during an interview with the surveyor, the Registered Nurse/Unit Manager (RN/UM #1) replied, Yes. [He/She] should have them [floor mats] by the bed. At the time of the interview the surveyor showed RN/UM #1 the bilateral floor mats placed against the walls in Resident # 97's room. On 02/06/2024 at 4:00 PM, during an interview with the surveyor, the Director of Nursing said the bilateral floor mats should not have been folded against the wall. During the same interview, the Regional Nurse #1 replied, Injury could occur when the surveyor asked what potential results could have occurred if the floor mats were not placed according to the order. (continued on next page)

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	315340	A. Building B. Wing	02/08/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Comprehensive Care Plans with a copyright date of 2023, revealed under subsection, Policy Explanation and Compliance Guidelines number 3. letter a. that, The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. S 8:39-27.1 (a)

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	315340	A. Building B. Wing	02/08/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49712 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the medication error rates are not 5 percent or greater. This deficient practice was identified for 2 of 5 residents (Resident #143 and Resident #147), and 1of 2 nurses on the second-floor nursing unit during the Medication Administration task. The deficient practice was evidenced by the following: On 02/01/2024 at 08:55 AM, during the medication administration, the surveyor observed the Licensed Practical Nurse (LPN) prepare and administer medications to Resident #143 which included Metformin HCL (a medication used for managing high blood sugar levels) 500 milligrams (mg). That medication had a pharmacy label on the package which instructed to give with food. The surveyor observed Resident #143 in their room as the LPN administered the medication. At that time, the surveyor did not observe any food available in the vicinity of the resident. The LPN did not offer the resident any food with the medication. On 02/01/2024 at 09:00 AM, during the medication administration, the surveyor observed the LPN prepare and administer Avacopan (a medication used to treat a group of rare autoimmune conditions that causes an inflammation of blood vessels) 10 mg to Resident #147. That medication had a pharmacy label on the package which instructed to give with food. The surveyor observed Resident #147 in their room as the LPN administered the medication and the LPN did not offer the resident any food with the medication. The surveyor observed a covered meal tray next to the resident. The LPN did not ask the resident if he/she ate their breakfast. On 02/01/2024 at 09:06 AM, the surveyor interviewed the LPN once she returned to the medication cart. The surveyor inquired as to what the policy was about medications that say to take with food. The LPN responded, I try to give meds [medications] to them around breakfast time. The trays come up [to the floor] at 8:35am. I saw the aides delivered trays. There are also snacks in the bottom drawer cart that we can offer with meds. At that time, when the LPN opened the bottom drawer of the medication cart, the surveyor observed no snacks in the drawer. On 02/06/2024 at 04:04 PM, during an interview with the Director of Nursing (DON) and [NAME] Nurse #2, the surveyor inquired as to the expectation when medications were marked to take with food. The DON replied, It should be taken with food, no crackers or cookies, it should be a meal. When the surveyor inquired as to whether the nurses should have assumed that the residents ate breakfast because they saw the food trays had been delivered, the Regional Nurse #2 responded, They should ask the resident or look at the resident's tray, they should not assume. Review of Resident #143's Admission Record reflected the resident was admitted to the facility with diagnosis which included but was not limited to type 2 diabetes mellitus without complications (disease affecting blood sugars) and antineutrophilic cytoplasmic antibody vasculitis (group of rare autoimmune conditions that causes an inflammation of blood vessels). (continued on next page)

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	315340	A. Building B. Wing	02/08/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #143's Physician Order Summary (POS) included an order for Metformin HCl 500 MG Tablet. Give 1 tablet by mouth two times a day for DM [diabetes mellitus] with a start date of 10/11/2023. The POS also included an order for Avacopan Oral Capsule 10 MG. The order specified to give 3 capsules by mouth two times a day for vasculitis to be administer with food. Medication should be swallowed whole. Do not crush, chew or open capsules. The order for the medication revealed a start date of 12/27/2023. Review of the facility's policy, Medication Administration, updated on 05/30/23, revealed under the subsection titled, Policy Explanation and Compliance Guidelines, #14 Administer medication as ordered in accordance with manufacturer, a. Provide appropriate amount food and fluid. N.J.A.C 8:39-29.2(d)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to maintain medications with appropriate dating of medications for 1 of 3 medication administration carts inspected and was evidenced by the following: On [DATE] at 10:43 AM, the surveyor inspected the medication storage cart labeled Cart A on the 2 (two) North Unit with the Licensed Practical Nurse (LPN). The surveyor identified that there was an undated opened foil package containing 17-unit dose vials of the medication Ipratropium Bromide/Albuterol (DuoNeb) used for nebulizer treatments. The surveyor interviewed the LPN at the time of the inspection who confirmed that the medication should have been dated when opened because the medication was only good for two weeks after the foil package was opened. On [DATE] at 10:53 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) for 2 North who stated that medications should have been dated when they were opened because some medications, once opened, expired quicker than other medications. The LPN/UM confirmed that all medications that were on the list of short expiration medications should have been dated when opened and that the nurse could have referred to this list if there were any questions regarding the expiration of medications. She added that the list of short expiration medications was in a book on the medication carts. The surveyor reviewed the list, located on the medication cart, titled, Pharma Accurate. The list contained the medication Ipratropium Bromide/Albuterol (DuoNeb) and indicated that the medication should have been discarded 7 to 14 days once removed from the foil package. On [DATE] at 01:05 PM, the surveyor interviewed the Pharmacy Consultant (PC) who stated that medications with short expiration dates must be dated when opened so that the nurses would have known when the medication would expire from that date. The PC confirmed that Ipratropium Bromide/Albuterol (DuoNeb) expired two weeks after the foil package was opened and that it should have been dated as soon as the nurse opened the foil package. The facility policy titled, Medication Storage indicated that it was the policy of the facility to ensure all medications houses on the premises will be stored in the pharmacy and/or storage rooms according to the manufactures recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. NJAC 8:,d+[DATE].4(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seashore Gardens Living Center	22 West Jimmie Leeds Road Galloway Township, NJ 08205

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 43307 Based on observation, interviews, record review and review of facility documentation, it was determined that the facility failed to properly execute its food and nutrition services by not following the established portion control procedure. This deficient practice was evidenced by the following: On 01/30/24 at 11:17 AM, the surveyor interviewed the Director of Dietary (DD) who stated that the facility utilized a four week cycle menu and that they were in week three. On 02/05/24 at 12:22 PM, in the presence of the DD, the surveyor observed the cook at the steam table plating food for the lunch meal. The cook was wearing a hair covering, surgical mask and gloves. The cook was observed to use the food scoop and tongs to plate the food, rested her hands on the counter, used the scoop and tongs again, then used her gloved hand to remove whole green beans from the steam table and placed them on a plate, rested her hands on the counter, touched the front of her surgical mask, then used the scoop to plate food again. On 02/02/24 at 12:24 PM, the surveyor interviewed the cook who stated her role was to get the plate, place the food that was called out on to the plate, and then pass it to the dietary aide. The cook was made aware of the surveyor's observation when she used her hands to serve the green beans. The cook acknowledged that she should not have used her hands to serve the food and stated that she was in a hurry and trying to get the food out of the kitchen. The cook stated that it was important to use the utensils to serve the food to prevent cross contamination. The surveyor inquired as to the portion size that was served on each plate and the cook stated, the scoop is four ounces. On 02/05/24 at 12:28 PM, the surveyor interviewed the DD who acknowledged that the cook plated the green beans with her hands. The DD stated that the cook should not have used her hands and that she should have used the tongs to serve the vegetables. The DD stated that it was important to use the scoop because it was a four-ounce (oz) measure for portions and that the portion sizes were established guidelines. The surveyor inquired that if the cook used her hands to serve the food how would she have known the portion size. The DD stated the cook did not know the portion size with her hands and that the scoop was accurate. The DD acknowledged that the use of hands to serve the food did not ensure an accurate four oz portion and that the cook would not have known the portion size using the tongs either. The DD stated that the cook should have used the scoop or spoodle (perforated measured spoon) to serve the green beans. On 02/05/24 at 01:07 PM, the surveyor interviewed the cook and inquired as to whether she knew what portion size to serve on meal trays. The cook stated that everyone got the same portion or if she was told it was a double portion that they would get double the protein. The cook stated that she knew what a portion size was because she had been doing this a long time. When the surveyor inquired about the portion size using her hands, the cook stated that it was the same as the tongs, my finger is just as long as the tong. The cook further stated that it was important to make sure the portion size was correct because she wanted to give the residents enough food to eat and that she did not want them to go hungry. (continued on next page)

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	315340	A. Building B. Wing	02/08/2024

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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/24 at 11:30 AM, the surveyor interviewed the Corporate Registered Dietician (CRD) who stated she was contracted and that today was her first day in the facility. The CRD stated that portion sizes were determined, and most facilities would use a scoop and that it would have depended on whatever the menu extension was. The CRD was unable to speak to where the portion size information came from and who made the menu. The CRD stated that the cook should have used whatever scoop was indicated for that item. She stated that whatever company the facility used that they would use the menu extensions and serving sizes from their menu. The CRD stated, Usually whatever company comes in will have a Registered Dietician from that company that develops the menu. On 02/06/24 at 04:09 PM, the administration team was made aware of the kitchen concerns. At that time, the surveyor interviewed the Regional Nurse (RN) about meal portion sizes. The surveyor inquired as to what the expectation was for kitchen staff to accurately portion the food. The RN stated the cook should not have used her hands but should have used the appropriate scoops, spoodle, ladle, or premeasured devices to ensure the proper nutritional caloric intake of each resident. During the interview with the RN, the Regional Licensed Nursing Home Administrator stated the importance of accurate food portioning was adequate nutrition and intake for the resident. A review of the facility documentation, Week 4 menu, dated 11/29/23, revealed the menu on 02/05/24 included Seasoned [NAME] Beans. A review of the facility documentation, Master Menu, September 2023, Week: 4, Day: MONDAY, revealed under MENU ITEM in the LUNCH column was [NAME] Beans, and the portion size listed under the REGULAR column was 1/2 cup. A review of the facility documentation, Operations Policy and Procedure Manual Job Descriptions: Cook, revised 2/25/2008, revealed Duties and Responsibilities: Dietary Service: 3. Serve food in accordance with established portion control procedures. A review of the facility policy, Maintaining a Sanitary Tray Line, revised 3/2023, revealed Compliance guidelines: 3. During tray assembly, staff shall: b. Use utensils such as tongs, serving spoons, etc. to handle food as much as possible. NJAC 8:39-17.2(a); 17.4(a)(3)

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	315340	A. Building B. Wing	02/08/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43307 Based on observation, interviews and review of facility documentation it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses and b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination, and c.) maintain adequate infection control practices during food service in the kitchen. This deficient practice was observed and evidenced by the following: On 01/30/24 at 10:01 AM, the surveyor arrived in the kitchen and was informed by the [NAME] that the Director of Dietary (DD) was not on location. At 10:06 AM, in the presence of the Cook, the surveyor toured the kitchen and observed the following: 1. On a rolling metal rack in the dairy refrigerator, there were four trays containing oval tan patties, that the [NAME] identified as hash browns, that were uncovered with no label or dates. The [NAME] acknowledged the trays should have been covered, labeled and dated. There was one 3.5 pound (lb) opened package of [NAME] that was wrapped in clear plastic wrap with no open or use by date. The [NAME] stated that he did not know when it was opened and that it should have had a label marked when it was opened. The [NAME] stated it was important to make sure food was labeled and dated when it was opened so the staff knew when the food would have gone bad. The [NAME] stated they would be thrown away. There was one opened plastic bag marked grated parmesan cheese that was wrapped in clear plastic wrap with no open or use by dates. There was one opened plastic bag marked mozzarella cheese that was wrapped in clear plastic wrap with no open or use by dates. The [NAME] was unable to state when they could have been used by and stated he would discard them. At 10:16 AM, the Director of Dietary (DD) joined the tour, and the [NAME] left the area. 2. In the freezer, there was one box marked pancakes with the inner clear plastic bag open with the pancakes visible and open to air. The surveyor inquired as to whether the pancakes should be visible and open to air and the DD stated no, because something could have been wrong with them, and that she would throw them away. There was one tied clear plastic bag containing round tan dough with brown chips, with no label or dates. The DD stated the bag contained chocolate chip cookies and acknowledged that the bag had no label. The DD stated the bag should have had a label marked with the date that they were opened to make sure they were not old and out of date. There were two white undated cardboard packages marked cherry blintzes. The packages had tan stains and the edge of the packages were opened with the blintzes visible and open to air. The DD acknowledged the blintzes were not wrapped nor stored correctly and stated they should have been dated when they were taken out of the box. The DD removed them from the freezer. 3. In the can section in the dry storage room, there was one 6 lb dented can of crushed pineapple, one 106 ounce (oz) dented can of tropical fruit salad, and two 6 lb 10 oz dented cans of pumpkin. The DD removed the cans to the dented can section. (continued on next page)

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	315340	A. Building B. Wing	02/08/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. In the working supply overflow can section in the kitchen, there was one 6 lb 7 oz dented can of stewed tomatoes. The DD acknowledged the dented cans and removed them to the dented can section. The DD and stated it was important that the cans were not dented to prevent illness. 5. There was an uncovered mixer with the bowl visibly clean with white debris noted behind the bowl on the stand and brown debris on the handle. The DD acknowledged the debris, stated it should have been wiped and that it was important to keep the mixer clean to prevent cross contamination. 6. In the dairy prep area, there was one roll of clear plastic wrap that was uncovered and exposed and one roll of foil that was uncovered and exposed. The DD stated that the clear plastic wrap and the foil were used to cover pans and that they should not have been open and exposed because dust could have gotten on them. 7. In the spice area, there was one opened 16 oz jar of white pepper, one opened 18 oz jar of garlic powder, one opened 1 lb jar of celery seed, all with no open or use by dates and no expiration dates. The DD stated that the spices should have been dated when they were opened and threw the spices into the trash. 8. In the meat refrigerator, there was a large roasting pan partially covered with a sheet pan, with the meat visible and open to air and a label marked beef 1/30. The DD identified the meat as brisket and stated the meat should not have been visible. 9. In the freezer, there was a half pan covered with clear plastic wrap that was covered with ice with no labels or dates. The DD identified the contents as chicken backs bones and stated that it should have had a label with the date that the chicken was put in the freezer. The DD stated it was important that food was labeled and dated to ensure that it did not become potentially hazardous. The DD removed the pan from the freezer. Stuck to the underside of that half pan was a plastic bin that contained six packages of individually wrapped dark red meat, that the DD identified as beef [NAME], that had ice and frozen red liquid in the bags. There were no labels and no dates. Stuck to the underside of the plastic bin was a sheet pan that contained a tied bag of frozen tan meat with no label and no dates. The DD identified the meat as chicken legs. Resting under the sheet pan was a cardboard box labeled boneless shank meat, dated 2021. Inside the box was a knotted clear plastic bag that contained seven beef [NAME] with visible ice on the meat and in the bag, and a large piece of ice resting on the bag. The DD stated the meats were not stored correctly and that they should have been labeled with the received dates and dated when they were prepped and placed into the freezer. The DD further stated that it was important to store and label food correctly for safety, to decrease cross contamination and for the prevention of food borne illness. 10. In the dry storage area spice cabinet, there was one opened 8 oz jar of white pepper, one opened 12 oz jar of ground basil, one opened 1 lb jar of ground ginger and one opened 18 oz jar of garlic powder with no open or use by or expiration dates. The DD stated the spices should have been marked when they were opened and then disposed of them in the trash. 11. In the cook prep area, there was one roll of clear plastic wrap that was opened and uncovered. The DD stated the plastic wrap was used to cover food and that it should have been covered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. Building B. Wing	02/08/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/05/24 at 12:22 PM, in the presence of the DD, the surveyor observed the cook at the steam table plating food for the lunch meal. The cook was wearing a hair covering, surgical mask and gloves. The cook was observed to use the food scoop and tongs to plate the food, rested her hands on the counter, used the scoop and tongs again, then used her gloved hand to remove whole green beans from the steam table and placed them on a plate, rested her hands on the counter, touched the front of her surgical mask, then used the scoop to plate food again. On 02/02/24 at 12:24 PM, the surveyor interviewed the cook who stated her role was to get the plate, place the food that was called out on to the plate, and then pass it to the dietary aide. The cook was made aware of the surveyor's observation when she used her hands to serve the green beans. The cook acknowledged that she should not have used her hands to serve the food and stated that she was in a hurry and trying to get the food out of the kitchen. The cook stated that it was important to use the utensils to serve the food to prevent cross contamination. On 02/05/24 at 12:28 PM, the surveyor interviewed the DD who acknowledged that the cook plated the green beans with her hands. The DD stated that the cook should not have used her hands and that she should have used the tongs to serve the vegetables. The DD further stated that it was important to use the utensils to serve the food to prevent cross contamination. A review of the facility policy, Maintaining a Sanitary Tray Line, revised 3/2023, revealed Policy: This facility prioritizes tray assembly to ensure foods are handles safely and held at proper temperatures to prevent the spread of bacteria that may cause food borne illness. Compliance guidelines: 3. During tray assembly, staff shall: b. Use utensils such as tongs, serving spoons, etc. to handle food .g. Change gloves after sneezing, coughing or touching face, hands or hair with gloved hand. A review of the facility documentation, Operations Policy and Procedure Manual Job Descriptions: Cook, revised 2/25/2008, revealed Duties and Responsibilities: Safety and Sanitation: 2. Ensure that safety regulations and precautions are followed at all times by all personnel. 3. Follow established Infection Control and Universal Precautions policies and procedures when performing daily tasks. NJAC 8:39-17.2(g)

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	315340	A. Building B. Wing	02/08/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43936 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident's medical record contained an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, specifically by failing to include pertinent information in the electronic medical record. The deficient practice was discovered for 1 of 1 resident (Resident # 150) reviewed for Medical Records. The deficient practice was evidenced by the following: A review of Resident #150's Electronic Medical Record (EMR) under Progress Notes revealed that he/she was discovered by staff not breathing. The note revealed that the Nurse Supervisor was notified and Resident #150 was declared deceased . The note concluded by revealing that the physician, family, funeral home, and facility administration were notified. A review of Resident #150's physician's orders in the EMR revealed that Resident #150 was a Full Code, meaning life saving measures would have been implemented if the Resident's health declined. A review of the facility provided document titled, Timeline revealed a description of events by date and time leading up to Resident #150's death. The timeline revealed that on [DATE] at 05:40 AM, Cardiopulmonary Resuscitation (CPR) was initiated by the assigned nurse. The document concluded that CPR was discontinued at 05:50 AM. The document further revealed that Resident #150 was unresponsive, cold to touch, and displayed rigidity (inability to be moved out of shape). A review of the facility provided document titled, Witness Statement that was completed by the Registered Nurse present at the time of Resident #150's death confirmed that CPR was initiated around 05:45 AM on [DATE]. The document further revealed that once the physician was notified, CPR was discontinued around 5:50 AM. A review of the document titled, Abstract of Death Certificate Information revealed that Resident #150's immediate cause of death was a Cerebrovascular Accident (damage to the brain from interruption of its blood supply). The document further revealed that the manner of death was natural. On [DATE] at 04:02 PM, during an interview with the surveyor, the Director of Nursing (DON) confirmed CPR was initiated at the time Resident #150 was discovered not breathing. The DON further described that Resident #150 appeared to have been in rigor mortis (stiffening of the joints and muscles of a body after death). On [DATE] at 10:03 AM, during an interview with the surveyor, the Unit Manager/Registered Nurse replied, Of course when asked if CPR had to be documented in a resident's progress note. (continued on next page)

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	315340	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:36 AM, during an interview with the surveyor, Regional Nurse #1 replied, Yes, absolutely when asked if CPR should have been included in the progress notes in the EMR. Regional Nurse #1 said at the time the nurse documenting could not access Resident #150's record due to Resident #150 being discharged from the EMR. A review of the facility provided policy titled, Documentation of Medical Record revealed, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. N.J.A.C. S 8:,d+[DATE].2 (d) 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. Building B. Wing	02/08/2024

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 33106 Based on interview and record review, it was determined that the facility failed to ensure that the required members were present during the quarterly Quality Assessment and Assurance (QAA) committee meetings. This deficient practice occurred during 1 of the 4 meetings and was evidenced by the following: On 02/07/24 at 09:52 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the Quality Assurance Performance Improvement (QAPI) process in the facility. According to the data provided by the facility, there was no physician, including the Medical Director (MD) or another designated physician, in attendance at the quarterly Quality Assurance (QA) meeting that was held on 05/11/23. On 02/07/24 10:30 AM, the surveyor reviewed the quarterly QA minutes in the presence of the LNHA. The LNHA stated that according to the attendance sign out sheet the MD did not sign that he was in attendance. The surveyor did observe that the minutes that were documented after the meeting were signed by the Medical Director. The LNHA stated that these minutes were typed by the secretary after the meeting and was not sure when the MD signed the minutes. The LNHA stated that she could not recall if the MD was at the quarterly QA meeting because he did not sign the attendance sheet at the time the meeting was held. The facility policy titled, Quality Assessment and Assurance Plan, dated 01/2024, indicated that QAPI was incorporated into the facility culture throughout all disciplines, service lines, to include board of directors and leadership. NJAC 8:39-33.1(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. Building B. Wing	02/08/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43307 Complaint NJ # 165358 Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to follow appropriate infection control practices and perform hand hygiene as indicated: a) during a meal tray pass observation for 1 of 4 units, (2 North unit), b) during medication administration for 1 of 3 residents observed (Resident #143), and c) during wound care for 1 of 3 residents observed (Resident #65). The deficient practice was evidenced as follows: 1. On 01/30/24 at 12:34 PM, the covered food cart arrived on The [NAME] hallway on Unit 2 North. At 12:51 PM, surveyor #1 observed a Certified Nursing Aide (CNA #1) who approached the food cart, removed a tray from the cart, entered Resident # 302's room and placed it on their bed side table (BST). CNA #1 then removed the lid from the foam cup, removed the lid from the orange soda bottle that was previously resting on the Resident's BST, poured the soda into the foam cup and replaced the lids on the soda and the foam cup. CNA #1 then removed the wrapping from the straw and placed the straw into the foam cup lid, removed the plastic plate cover and exited the room. CNA #1 returned to the food cart and placed the plastic plate cover on top of the food cart, removed a meal tray from the cart and entered Resident #303's room and placed the meal tray on the BST. CNA #1 returned to the food cart, removed a tray, and placed it on top of the food cart. CNA#1 partially lifted the lid from the ice cream, removed the silverware from the plastic baggie with her hands and placed them on the tray, opened a can of cola and poured the contents into a foam cup, placed a lid on the cup, removed half the straw wrapper and placed the straw into the lid of the foam cup. CNA #1 then entered Resident #72's room and, while holding the meal tray in her left hand, used her right hand to remove trash from the BST and throw it into the trashcan. CNA #1 then placed the meal tray on the BST, moved the Resident's wheelchair closer to his/her bed, removed a blanket from the Resident, moved the Resident's legs over the side of the bed, assisted the Resident to sit up on the side of the bed, then provided hands on assistance to transfer the Resident to the wheelchair and repositioned the Resident once in the wheelchair. CNA #1 then moved the wheelchair closer to the bed, moved the BST in front of the Resident, removed the lid from the soup, removed the lid from the ice cream, moved the foam cup closer to the Resident, removed the plastic lid from the plate and exited the room. CNA #1 placed the plastic lid on top of the food cart then moved the beverage cart, that was next to the food cart, into the snack room, opened the refrigerator and placed the containers of juice into the refrigerator. No hand hygiene was observed during the observation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/30/24 at 12:58 PM, surveyor #1 interviewed CNA #1 who stated that when the food carts arrived on the unit that it was the CNA and nurse's responsibility to check the trays for accuracy and to serve the trays to the residents. CNA #1 stated during meal tray pass that hand hygiene (HH), which she explained was washing with soap and water or using hand gel, should have been done before meal tray pass was started, when it was completed, and that sometimes she performed HH in between if she touched their stuff like silverware or cups and continued, I was rushed today because the trays were late. Surveyor #1 informed CNA #1 of the meal tray pass observation and that no HH was observed. CNA #1 acknowledged that she did not perform HH between passing each resident's tray and that she should have performed HH after delivering Resident #302's tray. CNA #1 stated that it was important to have performed HH correctly to prevent cross contamination and shared germs. On 01/30/24 at 01:15 PM, surveyor #1 interviewed the Licensed Practical Nurse (LPN #1) who stated that it was the CNA's responsibility to distribute meal trays on the unit and that HH should have been performed between each tray that was passed. Surveyor #1 informed LPN #1 of the CNA's meal tray pass observation. LPN #1 stated that CNA #1 did not perform HH correctly and that she should have cleaned her hands before and after touching each tray. LPN #1 further stated that it was important to perform HH correctly, so germs were not transferred from resident to resident. On 01/30/24 at 01:26 PM, surveyor #1 interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #1) who stated that staff were responsible for the distribution of meal trays on the unit and that she expected staff to perform HH before and after obtaining a meal tray and serving the next resident. Surveyor #1 informed the LPN/UM #1 of the CNA's meal tray pass observation. LPN/UM #1 acknowledged that CNA #1 did not perform HH correctly between each resident and stated that HH was important so germs were eliminated, and contamination was avoided. On 02/01/24 at 10:42 AM, surveyor #1 interviewed the Assistant Director of Nursing (ADON) who stated that it was the CNA's responsibility to distribute meal trays on the unit and that HH should have been performed after the resident's trays were set down, if the CNA had to help the resident open food items, any contact with the resident, and when anything was touched. Surveyor #1 informed the ADON of the CNA's meal tray pass observation from 01/30/24. The ADON stated that CNA #1 did not perform HH correctly and that it was important for proper HH to prevent food borne disease and passing of germs. On 02/01/24 at 11:26 AM, surveyor #1 interviewed the Infection Control Nurse (ICN) who stated that during meal tray pass, she expected HH to be performed when the trays were touched or when food was opened for a resident. Surveyor #1 informed the ICN of the CNA's meal tray pass observation from 01/30/24. ICN stated that CNA #1 did not perform HH correctly and that it was important for proper HH to prevent the spread of germs or infection. On 02/01/24 at 11:41 AM, surveyor #1 interviewed the Director of Nursing (DON) who stated that the CNAs passed the meal trays to the residents, and she expected HH to have been performed every time they touched anything or they go to get another tray on the cart. Surveyor #1 informed the DON of the CNA's meal tray pass observation from 01/30/24. The DON acknowledged that CNA #1 did no HH and that she expected staff to perform HH between each resident. The DON stated that it was important to perform HH correctly to prevent the passing of germs. On 02/06/24 at 03:39 PM, the surveyors met with the administration team who were made aware of CNA #1's meal tray pass observation from 01/30/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seashore Gardens Living Center	22 West Jimmie Leeds Road Galloway Township, NJ 08205

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility documentation revealed Meeting Sign-In Sheets for topics which included: Hand Hygiene . signed by CNA #1 and dated 11/29/23, and 12/12/23. A review of facility documentation, dated 12/02/23 and 01/10/24, revealed a Hand washing observation performed by CNA #1, and rated A=Performs skill independently and completely. Both forms were signed by an Observer. A review of facility documentation revealed an Employee Education Packet, Hand Hygiene, dated 11/29/23, for CNA #1 with Competency Demonstrated box checked YES and Observer Initials marked. 49712 2. On 02/01/2024 at 08:55 AM, during the Medication Administration task on 2 South unit, surveyor # 2 observed LPN # 2 administering medications to Resident # 19. Upon finishing the medication administration, surveyor # 2 observed LPN #2 exit the room and approach the medication cart. Surveyor # 2 then observed LPN #2 prepare medication for Resident #143. LPN #2 did not perform hand hygiene between finishing the medication administration with Resident # 19 and beginning the medication administration for Resident #143. During an interview with surveyor # 2 at that time, LPN #2 was asked when hand washing was to be performed and LPN #2 stated, between residents. When asked if she had washed her hands between Resident #19 and Resident # 143, LPN #2 responded, No, I forgot. On 02/01/24 at 11:37 AM, surveyor # 2 interviewed the Infection Preventionist (IP) who was asked when hand hygiene should have been done during medication administration. The IP stated, hand hygiene should be done prior to starting, and after giving medication. They should use hand sanitizer or washing hands with soap and water. It is recommended to wash with soap and water every three patients. 49175 3. On 02/02/24 at 11:00 AM, on 2 South Unit, surveyor #3 observed LPN#3 perform a wound care treatment for Resident #65, assisted by CNA#2. LPN/UM#2 was also present for the observation. LPN/UM #2 stated she was there to observe the wound care task, to complete competencies for LPN#3, and as moral support. Surveyor #3 observed CNA #2 enter the resident's room and don gloves. She then assisted LPN #3 in repositioning Resident #65's incontinence diaper which was opened in the front, while the back of incontinence diaper was pulled down. CNA#2 then rolled the resident to their left side allowing LPN#3 to perform the wound care. At that time, CNA#2 held the resident in the side position by placing her gloved hands-on the resident's buttock area and lower back. LPN#3 then proceeded to complete the wound care on resident #65. With the same gloves, CNA#2 and LPN#3 redressed the resident, reapplied the incontinence diaper, and repositioned the resident. With the same gloves, CNA#2 then held the resident's hands, repositioned the resident's blankets, and adjusted the bed pillows. CNA#2 then removed her gloves and proceeded to the bathroom to wash her hands with soap and water for 40 seconds. On 02/02/24 at 11:25 AM, surveyor#3 interviewed CNA#2 and made her aware of the wound care observations. CNA #2 stated that she was not aware of any breach in the infection prevention protocol and was not aware she did not change her gloves. CNA#2 stated she should have changed her gloves and that improper hand hygiene could have spread infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seashore Gardens Living Center	22 West Jimmie Leeds Road Galloway Township, NJ 08205

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/02/24 at 11:35 AM, surveyor#3 interviewed LPN/UM#2 and discussed the wound care observation. LPN/UM#2 stated that CNA#2 should have changed her gloves after she assisted with the dressing change, before she proceeded to reposition the resident, and when she touched the resident's hands. A review of the facility policy, Hand Hygiene, accessed June 2023, revealed, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or use of an antiseptic hand rub .Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. The handout Hand Hygiene Table revealed Condition: Between resident contacts, After handling contaminated objects, Before preparing or handling medications, Before and after handling clean or soiled dressings, linens etc., After handling items potentially contaminated with blood, body fluids, secretions, or excretions, When, during resident care, moving from a contaminated body site to a clean body site . A review of the undated facility policy, Nursing Pertinent Policies, revealed, Assisting the Resident with In-Room Meals, Preparation: 11. Employees must wash their hands before serving food to residents .if there is contact with soiled dishes, clothing or the resident's personal effects, employee must wash his/her hands before serving food to the next resident. NJAC 8:39-19.4 (m)(n)