PRINTED: 11/07/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245452			1	С	
		315453				05/	/29/2024
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLETE CARE AT SHORROCK					75 OLD TOMS RIVER ROAD BRICK, NJ 08723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
	Complaints NJ #: 15 164199; 169902; 170	7735; 160630; 161027; 619; 172027					
	Survey Date: 5/29/24						
	Census: 158						
	Sample: 32 + 3						
	·	with 42 CFR Part 483, ng Term Care Facilities.					
F 609 SS=D	Reporting of Alleged V CFR(s): 483.12(b)(5)	Violations	F 6	609			7/19/24
		se to allegations of abuse, or mistreatment, the facility					
	involving abuse, negli- mistreatment, includir source and misappro- are reported immedia hours after the allega that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of the officials (including to a adult protective service for jurisdiction in long	ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

Facility ID: NJ656003

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.

**Electronically Signed** 

06/10/2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		315453	B. WING			05/29/2024		
	ROVIDER OR SUPPLIER	<b>S</b>		7	TREET ADDRESS, CITY, STATE, ZIP CODE 5 OLD TOMS RIVER ROAD RICK, NJ 08723			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 609	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective. This REQUIREMENT by:  Based on interview a facility documents, it facility failed to notify of Health (NJDOH) at US FOIA (b)(6)  DUS FOIA (b)(6)  DUS FOIA (b)(6)  This defict of 1 of 6 DUS COTOGE 20.401 of and was evidenced by the survey of ask  During entrance confeand, the surveyor ask  During entrance confeand, the surveyor ask  On 5/24/24 at 9:35 Al from the DUS FOIA of the personal and medical	administrator or his or her active and to other officials in e law, including to the State in 5 working days of the eged violation is verified a action must be taken. Is not met as evidenced and review of pertinent was determined that the the New Jersey Department in who was discovered in a NJ Ex Order 26.4(b)(1) of a cient practice was identified employee files reviewed, y the following:  The effect of the survey team with a nired since last standard employed by the facility or revort requested the facility or revort requested the ployee files including a from the provided list.  The effect of the survey requested including a from the provided list.	F	609	Residents affected by deficient practice. The facility failed to notify the New Jers Department of Health (NJDOH) an allegation of neglect for a Certified Nursing Aide, CNA #1, who was discovered who reported they were under the NJ Exec Order 26.4b1.  Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected.  What corrective action will be accomplished for those residents affect by the deficient practice: All residents were monitored for any adverse effects with none noted. CNA #1 is no longer employed at the facility.  The facility notified the New Jersey Department of Health on US FOIA (b)(6)	eey		
	with a NJ Ex Order 26.4, with a	form dated effective summary for "staff			were reeducated on 6/4/2024 by the Regional Administrator	on		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315453 R WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 609 Continued From page 2 F 609 was observed to be NJ Ex Order 26.4b2 the requirements of reporting and . According to her, she stated she took investigating allegations of neglect and on too much of her NJ Ex Order 26.4(b)(1) and never the following facility policies: Abuse, brought in a script." Neglect, Exploitation and Misappropriation Prevention Program and Substance A review of the New Employee Abuse in the Workplace. Examination signed by CNA #1 on indicated for list of medical conditions was left All terminated employee files were audited blank, and the list of all medications you are by the Human Resources Director and currently using and indication of use did not ensured compliance with these policies. include NJ Ex Order 26.4(b)(1) The Director of Nursing, and Licensed Nursing Home Administrator conducted On 5/28/24 at 11:40 AM, the surveyor interviewed patient interviews on various units and regarding CNA #1's NJ Ex Order 28.4b ensured that there were no concerns , and the stated she received a phone call from the regarding any staff members, suspected U.S. FOIA (b) (6) that aide was NJ Ex Order 26.4(b)(1) and she was neglect, and abuse with no concerns NJ Ex Order 26.4(b)(1) in NJ Ex Order 26.4(b)(1). Staff voiced woke CNA #1 up and she stated she was tired and went back to work, but was found Measures or systematic changes to so she was sent home. The ensure that the deficiencies will not she spoke to CNA #1 the next day who stated reoccur: she said had been under NJ Ex Order 26.4(b)(1), and she The Human Resources Director or took too much of her NJ Ex Order 26.4(b)(1 Designee will conduct audits of 3 requested a copy of the prescription, and terminated employee files to ensure that the CNA stated she would provide the medication any allegations of neglect are reported stated when bottle, but she never did. The and investigated as required, and that all the facility suspected an employee reportable events and the following of the they were sent out to the hospital policy and procedures are completed. NJ Ex Order 26.4b1, but the facility did not Audits will be completed weekly X 4 CNA #1 because the aide stated she had a weeks then monthly x 2 months. Results NJ Ex Order 28.4(b)(1) that was never confirmed and the of audit will be reviewed at the Monthly CNA could not provide the name of the Quality Assurance Meeting and Quarterly NJ Ex Order 26.4(b)(1). The DON stated CNA #1 over the duration of the audit process to NJ EX Order 28.4(b)(1) so she never never brought in the ensure compliance and reassessed for worked again, and the us. Folk confirmed she did further action. not report the CNA's condition to any agency or licensing boards since the CNA was "just" The stated she was unsure who in the state would be notified.

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315453	B. WING		C 05/29/2024	
	NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT SHORROCK			STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	, 33-33-23	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 609	Continued From pag	ge 3	F 609	9		
	CNA #1's assignment as their time card, and regarding an employ.  A review of CNA #1's day she worked was 10:45 PM.  A review of the CNA 3:00 PM to 11:00 PM CNA #1 was assigned included twelve residuals with transferring from with five of the residuals assistive device that	Assignment sheet for the day, as well in the facility's policy were NJ Ex Order 26.4(b)(1).  It stime card revealed the last from 4:49 PM until from from from 4:49 PM until from from 4:49 PM until from from 4:49 PM until from from from from from from from from				
	of the U.S. FOIA (b)  JU.S. FOIA (b)  survey team, stated occurred on the facility the next of the stated CN  NJ Ex Order 26.4(b)(of the name, and ne The facility the name, and ne The facility the name, and ne The facility that the stated that the facility that the stated that CNA #1 a was fine, and staff next the following that the stated that CNA #1 a was fine, and staff next the stated that the facility that t	AM, the JS.FOIA (b) in the U.S. FOIA (b) (6), JS.FOIA (b) (6) eam stated the facility would				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG	(X3)	(X3) DATE SURVEY COMPLETED	
		315453	B. WING			C <b>05/29/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	I ≣	05/25/2024	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 609	the US. FOIA (b) (6) had obecause she was confirmed the Considents, and some should not be operat was a safety concern.  A review of the facility Exploitation and Misseman Program dated review of the facility Exploitation or misaperate and invincidents of abuse, not misappropriation of rand report any allegate required by federal residents of alcohol-free workplassafety of its residents of alcohol or illegal deposes a serious hear residentsstaff may Facilityconduct any while impaired on a sonot prohibit appropriation or other represcribed under both	n a Wex order 26.4(b)(1), and that called her that evening neerned with the CNA. The CNA had a full assignment of one with the CNA by a wex order 26.4(b) by a wing a wex order 26.4(b) by a wex order 26.4(b) ing a wex order 26.4(b) because it in.  The condition of the cause in the cause in the cause of the cause in the cause in order to maintain the cause of over the counter in medication when used to cause of over the counter in medication that can legally be the federal and state law, to	F	509			
	job performance or s	s not impair a staff member's afety or safety of othersa y is subject to disciplinary					

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		B) DATE SURVEY COMPLETED
	315453	B. WING _			C <b>05/29/2024</b>
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	<b>,</b>	00/20/2024
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE
action, up to and incluemployment.  NJAC 8:39-4.1(a)5	uding termination of				7/40/04
S483.12(c) (1) responsing neglect, exploitation, must:  §483.12(c) (2) Have eviolations are thorouged s483.12(c) (3) Preven neglect, exploitation, investigation is in programment investigation is in programment investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the all appropriate correctived This REQUIREMENT by:  Based on interview a facility documents, it is facility failed to invest when a USF discovered when reported the of a Survey and the survey and th	se to allegations of abuse, or mistreatment, the facility vidence that all alleged hly investigated.  It further potential abuse, or mistreatment while the gress.  It he results of all administrator or his or her ative and to other officials in a law, including to the State in 5 working days of the eged violation is verified a action must be taken.  It is not met as evidenced and review of pertinent was determined that the igate an active and that the igate an action of was determined that the igate an active working that the igate an action of was determined that the igate an action of the state of the stat	F 6	F 610 Investigate / Prevent / 0 Alleged Violations  Residents affected by deficien " The facility failed to invest allegation of neglect when a C Nursing Aide, CNA #1, was dis	t practice: tigate an ertified scovered ent's room	7/19/24
	OVIDER OR SUPPLIER  E CARE AT SHORROCK  SUMMARY STA (EACH DEFICIENC' REGULATORY OR L  Continued From page action, up to and incluemployment.  NJAC 8:39-4.1(a)5 Investigate/Prevent/CCFR(s): 483.12(c)(2)- §483.12(c) In responsing neglect, exploitation, must:  §483.12(c)(3) Prevention in progression in progr	OVIDER OR SUPPLIER  E CARE AT SHORROCK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5 action, up to and including termination of employment.  NJAC 8:39-4.1(a)5 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to investigate an who reported they were NJ EX Order 26.4(b)(1)  This deficient practice was	OVIDER OR SUPPLIER  E CARE AT SHORROCK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5 action, up to and including termination of employment.  NJAC 8:39-4.1(a)5 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) \$483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: \$483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. \$483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  \$483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to investigate an who reported they were WEXCORDER  A BUILDIT  PREFID TAG  PR	OVIDER OR SUPPLIER  E CARE AT SHORROCK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 5 action, up to and including termination of employment.  NJAC 8:39-4.1(a)5 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2) (4) \$483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  \$483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  \$483.12(c)(2) Have evidence that all alleged violations is in progress.  \$483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:  Based on interview and review of pertinent facility failed to investigate an of when a US FOIA (b)(5) was discovered when a US FOIA (b)(5) was discovered when a US FOIA (b)(5) was discovered when a US FOIA (b)(6) was dientified for 1 of 6 limitation are sidentified of 1 of 6 limitation are sidentified on propriet of they were employee files employee files    STREET ADDRESS, CITY, STATE, ZIP CODE	OVIDER OR SUPPLIER  315453  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  75 OLD TOWS RIVER ROAD  BRICK, NJ 08723  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF CORRECTION  PREFIX  FROUDERS PLAN OF CORRECTION  SECOND STATEMENT OF SUMMARY STATEMENT OF SOME STATEMENT OF SUMMARY STATEME

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315453	B. WING			C 05/29/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	23/2024
					5 OLD TOMS RIVER ROAD		
COMPLET	E CARE AT SHORROCK				RICK, NJ 08723		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 610	Continued From page	e 6	F 6	310			
	During entrance conf AM, the surveyor ask ) to pro	erence on 5/20/24 at 9:54 ed the U.S. FOIA (b) (6) and u.s. FOIA (b) (6) vide the survey team with a uired since last standard			Identify those individuals who could be affected by the deficient practice:  " All residents have the potential to affected.		
	provide the reason fo				What corrective action will be accomplished for those residents affect by the deficient practice:  " All residents were monitored for a		
	from the us FOIA ten cur	ng personal and medical			adverse effects with none noted.  " CNA #1 is no longer employed at facility.  The U.S. FOIA (b) (6) and U.S. FOIA (b) (6)	the	
	A review of CNA #1's	files revealed the following:			re-educated on 6/4/2024 by the Region Licensed Nursing Home Administrator		
	The employee was hired on Employee NJ Exec Order 26.4b) form dated effective summary for "staff was observed to be NJ Ex Order 26.4(b)(1) of a NJ Ex Order 26.4(b)(1) According to her, she stated she took too much of her NJ Ex Order 26.4(b)(1)] and never brought in a				the requirements of reporting and investigating allegations of neglect and the following facility policies: Accident/ Incident Reporting, Abuse, Neglect, Exploitation and Misappropriation Prevention Program and Substance Abuse in the Workplace. Emphasis on reporting and investigating events	l on	
	indicated for list of me blank, and the list of a	edical conditions was left all medications you are dication of use did not			according to the long-term regulations, DOH Guidelines/ Reportable Grid and facility policy. With prompt reporting to NJDOH to be done by the Administrator/DON or the designee as regulation guidelines. The facility completed a full investigation.	the	
	the stated she rece U.S. FOIA (b) (6) that aide v NJ Ex Order 26.4(b)(1) in woke CNA #1 up and	she stated she was NJEXOTE k, but was found NJEXOTE 26.4T			" All terminated employee files were audited by the Human Resources Dire and ensured compliance with these policies.  Measures or systematic changes to ensure that the deficiencies will not		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315453	B. WING	_		l	20/2024	
NAME OF P	ROVIDER OR SUPPLIER	010400		S	TREET ADDRESS, CITY, STATE, ZIP CODE	05/	29/2024	
	E CARE AT SHORROC	к		75	5 OLD TOMS RIVER ROAD RICK, NJ 08723			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 610	she said had been took too much of her took too much of her requested a counter the CNA stated she whottle, but she never the facility suspected they was CNA tool and not provide prescribed medication never brought in the worked again, and the took any statements conducted an investional that time, the surve CNA #1's assignment as their time card, arregarding an employ A review of CNA #1's day she worked was 10:45 PM.  A review of the CNA #1's day she worked was 10:45 PM.  A review of the CNA #1's day she worked was 10:45 PM.  A review of the CNA #1's day she worked was 10:45 PM.  On 5/28/24 at 2:05 F	If the next day who stated J Exec Order 26.4b1, and she NJ Exec Order 26.4b1, and she py of the prescription, and would provide the medication of did. The stated when do an employee being stated when do an employee which included twelve	F	510	reoccur:  " The DON/HR Director /Designee v conduct audits of employee files to ensithat any allegations of neglect are reported and investigated as required at the following of the policy and procedur on reporting and investigating reportable events. Audits of 3 employee files will be completed weekly X 4 weeks then monthly x 2 months. Results of the audill be reviewed at the Monthly Quality Assurance Meeting and Quarterly over duration of the audit process to ensure compliance and reassessed for further action.	ure and res le oe dits		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	COMPLETED	
		315453	B. WING		C <b>05/29/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	03/23/2024	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 610	occurred on the facility the next The stated CN Stated C	the incident with CNA #1  the incident with CNA returned to day to speak with the LNA #1 stated she was on an (1) that the aide was unsure ever provided the LNA #1 stated no written y staff.  A AM, the LNA #1 in the LNA #1 at the site was fine, and staff noticed iff she was fine, and staff noticed iff she was found LNA #1 at the site was found LNA #1 in a d that the LNA #1 in a d that th	F 61	0		
	Exploitation and Mi Program" dated rev protect residents fro exploitation or misa anyone including, b staffidentify and in incidents of abuse, misappropriation of and report any alleg required by federal A review of the faci Workplace" policy of facility is committed	ppropriation of property by ut not limited to: a. facility nvestigate all possible neglect, mistreatment, or resident property; investigate gations within the timeframes				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	COMP	(X3) DATE SURVEY COMPLETED	
		315453	B. WING _		C 05/29/2024		
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723		20/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 610	safety of its residents of alcohol or illegal dr poses a serious healt residentsstaff may be active the facilityconduct any while impaired on a sonot prohibit appropria and legal prescription treat a disabilitynot prohibit the appropria medication or other more prescribed under both the extent that it does job performance or se	being under the influence rugs while at the facility thand safety risk to all not present in the Facility-sanctioned task ubstancethis policy does te use of over the counter medication when used to hing in this policy is meant to te use of over-the-counter nedication that can legally be nederal and state law, to so not impair a staff member's afety or safety of othersa	F6	10			
F 677 SS=E	S483.24(a)(2) A reside out activities of daily be services to maintain opersonal and oral hygometric This REQUIREMENT by: Complaint NJ#: 1606 172027  Based on observation pertinent facility document that the facility failed STEX COURTE (STEX) are was	is not met as evidenced 330; 169902; 170619;  n, interview, and review of ments, it was determined	F 6	F677 ADL Care for Provided for Dependent Residents  Resident affected by deficient practing facility failed to a.) ensure that the facility failed to a.) ensure that the facility failed to a. ensure that the failed to a.	ctice: it o idents nds	7/10/24	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-COMPLETED AND PLAN OF CORRECTION A. BUILDING 315453 R WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 677 Continued From page 10 F 677 J Ex Order 26.4(b)(1) rounds (Residents #94, #16, #8, on 1 of 2 nursing units (Applewood), and #109 and #137) on 1 of 2 nursing units b.) provide activities of daily living (ADL) (Applewood), and b.) provide activities of daily care for 4 of 7 residents reviewed for ADL living (ADL) care for 4 of 7 residents reviewed for care (#95, 94, #109 and #16). ADL care (# 95, #94, #109 and #16). Identify those individuals who could be This deficient practice was evidenced by the affected by the deficient practice: following: All residents have the potential to be affected. 1. On 5/20/24 at 11:41 AM, the surveyor observed What corrective action will be Resident #94 in bed. The Resident's Representative (RR #1) informed the surveyor accomplished for those residents affected that Resident #94 had not received care that by the deficient practice: morning, which included NJ Ex Order 26.4(b)(1) care, and Residents #94, #16, #8, #109, and #137 was still NJ Ex Order 26.4(b)(1) from last night. were provided with the appropriate UEX Order 28.4(b)(1) care and residents #95 and At that time, Resident #94 nodded in agreement. #94 received NJEX Order 25.40 per their On 5/20/24 at 11:52 AM, the surveyor found preferences as scheduled. Resident #94's Certified Nursing Assistant (CNA Residents #109 and #16 had their nails #1) who confirmed she was the resident's aide for clipped and cleaned as required. the day, and stated she had provided All residents were monitored for any NJ Ex Order 26.4b1 earlier that shift. The surveyor adverse effects with none noted. accompanied by CNA #1, entered the resident's Director of Nursing conducted facility wide room and pulled back the resident's blanket. It audit to ensure that all patients have had was revealed that the resident was NIEX OR their most recent scheduled shower. that wexage 26.4(b)(1 through their and and NUEx Order 26.4(b)(1 proper incontinence care, and had nail At that time, the surveyor observed a care completed as required per facility s . CNA #1 stated she had not provided care yet for that resident, and was All Registered Nurses, Licensed Practical previously mistaken. CNA #1 further stated that Nurses and Certified Nurses Aides were she had ten residents on her assignment that day reeducated by the Director of Nursing on and had not provided care. 6/4/2024 on facility policies: Activities of Daily Living (ADLs) Supporting to ensure Review of the CNA assignment sheet revealed compliance with the requirement. the unit had a census of 51 Residents with five assigned aides. CNA #1 had an assignment of Measures or systematic changes to ten residents on that shift. ensure that the deficiencies will not recur: The Director of Nursing or Designee will The surveyor reviewed the medical record for conduct 2 audits weekly for 4 weeks, then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315453	B. WING _	B. WING		C <b>05/29/2024</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/23/2024	
				75 OLD TOMS RIVER ROAD			
COMPLETE CARE AT SHORROCK				BRICK, NJ 08723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 677	Continued From page	÷ 11	F 6	77			
F 677	Resident #94.  A review of the Admis admission summary) was admitted to the faincluded NJ Ex Order, and NJ Ex Order, and NJ Ex Order Part of the included of the interview for mental s of 15, which indicate of 15, which i	sion Record face sheet (an reflected that the resident acility with diagnoses that 26.4(b)(1), NJEX ORDER 26.4(D)(1) order 26.4(b)(1).  recent quarterly Minimum ssessment tool dated resident had a brief tatus (BIMS) score of NJEX ORDER 26.4(b)(1) om staff for NJEX Order 26.4(b)(1) om staff for NJEX ORDER 26.4(b)(1) and was frequently and occasionally  fualized comprehensive care (NJEX ORDER 26.4(b)(1)) and ons included to change as soon as possible (ASAP) order 26.4(b)(1); keep (JEX ORDER 26.4(b)(1)); keep (JEX ORDER 26.4(b)(1)); keep (JEX ORDER 26.4(b)(1)) with interventions that 26.4(b)(1) with interventions that 26.4(b)(1) with NJEX ORDER 26.4(b)(1) with order 26.4(b)(1) ord	F 6	bi-weekly for 2 months to ensure residents are receiving showers incontinence care, and nail care scheduled and appropriate. Results of all audits will be revie Monthly Quality Assurance Mee Quarterly over the duration of the process to ensure compliance a reassessment for further action.	, e as ewed at the ting and le audit ind		
	On 5/24/24 at 10:17 A	AM, the surveyor interviewed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			C <b>05/29/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 75 OLD TOMS RIVER ROAD BRICK, NJ 08723		33/23/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 677	hours on the day shift  On 5/29/24 at 10:13 A presence of the U.S. FOIA (b) (6) acknows acknowled be provided et  2. On 5/22/24 at 7:45  VIEX OTGET 20:4(D)(1) rounds of the could be dith an acknowled be dith an acknowled be dithered by the extent of the could not have been designed aides on the (11-7) shift. The residual and assignment shift.  The surveyor reviewed Resident #16.  A review of the Admistreflected that the resifacility with diagnoses NJ Ex Order  NJ Ex Order	who confirmed that ould be done every two to to the ould be done every two to to the ould be done every two to to the ould be done every two to the ould be seen ours and agreed that, given that was and agreed that, given the resident's the resident's of 52 Residents with three to 11:00 PM to 7:00 AM dent's assigned CNA (CNA ant of 18 residents on that the output of the resident's assignment sheet revealed to 11:00 PM to 7:00 AM dent's assigned CNA (CNA ant of 18 residents on that the determinant of the resident's output of the resident of the resident was admitted to the set that included the resident of the resident was admitted to the set that included the resident of the resident was admitted to the set that included the resident was admitted to the set that the resident was a set that the resident was admitted to the resident was admitt	F6				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 315453 B. WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 677 Continued From page 13 F 677 NJ Ex Order 26.4(b)(1) 9:24 AM, the surveyor attempted a phone interview with the CNA #2 with no answer. On 5/24/24 at 10:17 AM, the surveyor interviewed the who confirmed that WEX Order 26.4(b)(1) care should be provided every two hours on the day shift and twice on the night shift. The first NJ Ex Order 26.4(b)(1) rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. in the On 5/29/24 at 10:13 AM, the I.S. FOIA (b) (6), and presence of the U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b)(1) should be provided every two hours. 3. On 5/20/24 at 12:13 PM, the surveyor observed Resident #8 in their room seated in a wheelchair. The Resident's Representative (RR #2) stated that on Saturday, he/she observed the resident's clothing was NJ Ex Order 26.4(b)(1) and observed a NJ Ex Order 26.4(b)(1) on the floor under

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	315453		B. WING	B. WING		C <b>05/29/2024</b>	
	ROVIDER OR SUPPLIER	<b>(</b>		STREET ADDRESS, CITY, STAT 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	TE, ZIP CODE	03/23/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 677	Resident #8 in his/he wheelchair with CNA surveyor observed a the room. CNA #3 acconfirmed that the resident #8.  Upon make stated, "not sure what further acknowledged that day.  On 5/22/24 at 7:41 A rounds, the surveyor an NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(1) a language of the surveyor and that time, the surveyor and the surveyor and NJ Ex Order 26.4(b)(1) a language of the surveyor review of the 11-7 C revealed the unit had with three assigned a assignment of 18 resident #8.  A review of the Admirreflected that the resident #8.	AM, the surveyor observed er room seated in a .#3 in the room. The NJ Ex Order 26.4(b)(1) in cknowledged the NJ Ex Order 26.4(b)(1), order 26.4(b)(1) were all NJ Ex Order 26.4(b)(1), order 26.4(b)(1) were all NJ Ex Order 26.4(b)(1), order 26.4(b)(1) were all NJ Ex Order 26.4(b)(1) were all NJ Ex Order 26.4(b)(1) observed the resident #8 for  M, during the NJ Ex Order 26.4(b)(1) pads that and NJ Ex Order 26.4(b)(1) the extraction of the surveyor interviewed the that placing NJ Ex Order 26.4(b)(1) was unacceptable and that it der 26.4b1.  ENA assignment sheet a census of 52 Residents aides. CNA #4 had an sidents on that shift.  ENA des in Record face sheet ident was admitted to the sthat included NJ Ex Order 26.4(b)(1) and	F	577			
	A review of the most	recent comprehensive MDS					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		315453	B. WING			05/	29/2024
	OVIDER OR SUPPLIER  E CARE AT SHORROCK				STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723		
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	A review of the ICCP  NJ EX Order 26.4(b)(1) With r  NJ EX Order 26.4(b)(1) Intervention  Interventions that inclumember for NJ EX Order  On 5/23/23 at 9:30 AN phone interview with the continuation of the c	hygiene.  included a focus area dated dent had the potential for regards to SAP after SECONDET 26.4(b)(1) and free of sample and included ADL with uded assistance of staff 26.4(b)(1) and SUEX OTOMET 26.4(b)(1) care very two hours on the day night shift. The first should be done between M, and then again between M. and then M. and M.	F	677			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315453 B. WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 677 Continued From page 16 F 677 4. On 5/22/24 at 7:32 AM, during rounds with the U.S. FOIA (b) (6) on the Resident #109 was observed in bed wearing an NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1) inside. Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift which included Resident #109. The surveyor reviewed the medical record for Resident #109. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included NJ Ex  $\overset{\circ}{\text{Order}}$   $\overset{26.4(b)(1)}{\text{o}}$  and NJ Ex Order 26.4(b)(1 A review of the most recent comprehensive MDS reflected the resident had dated and required NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) and A further review reflected that the resident was and A review of the ICCP included a focus area dated 1/3/22, that the resident was at risk for development due to aNJ Ex Order 26.4(b)(1) Interventions included to keep NUEX Order 25.4(b)(1) and change NJ Ex Order 28.4(b)(1) product ASAP after or NJ Ex Order 26.4(b)(1) On 5/24/24 at 10:17 AM, the surveyor interviewed who confirmed that should be provided every two hours on the day shift and twice on the night shift. The first rounds should be done between

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315453 B. WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 677 Continued From page 17 F 677 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. On 5/29/24 at 10:13 AM, the in the presence of the u.s. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b)(1 should be provided every two hours and that should not be placed inside NJ Ex Order 26.4(b)(1) unless requested by the family or the resident. The acknowledged that NJ Ex Order 26.4(b)(1) inside increased the chance of NJ Ex Order 26.4(b)(1 5. On 5/22/24 at 7:36 AM, during rounds, the surveyor and observed Resident #137 in bed with an NJ Ex Order 26.4(b) and a NJ Ex Order 28.4(b)(1) inside the Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift which included Resident #137 The surveyor reviewed the medical record of Resident #137. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included NJEX Order and NJ Ex Order 26.4(b)(1) A review of the most recent comprehensive MDS dated , reflected the resident had a BIMS score of out of 15, which indicated . A further review revealed the resident required NJ Ex Order 26.4(b)(1) with and

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315453	B. WING		C 05/29/2024
	ROVIDER OR SUPPLIER	ск		STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	03/23/2024
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F 677	On 5/24/24 at 10:17 the who confir should be provided shift and twice on the NJ Ex Order 26.4(b)(1) 12:00 AM and 7:00 A On 5/29/24 at 10:13 presence of the U.S. FOIA (b) (6) ack should be provided which inserting who confir should be provided (b) (c) ack should be provided (c) (c) (d) (e) (e) (e) (e) (e) (e) (e) (e) (e) (e	P included a focus area dated dent required assistance with ions that included to with ions that included to and with ions that included to and with ions that included to and with ions that included to with ions that included to with ions that included to with ions that with ions and that with ions ions and that with ions ions ions ions ions ions ions ions	F 67	7	
	get The surveyor review Resident #95.  A review of the Adm	e/she was "lucky" if they even week.  ved the medical record for hission Record face sheet sident was admitted to the			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		OATE SURVEY COMPLETED
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F 677	of Number of the of Number of Number of Number of 15, which is a further required Number of the ICCP of the of th	s that included and chronic the corder 25.4(b)(1) and chronic the chronic the corder 25.4(b)(1) and chronic the chronic the corder 25.4(b)(1) and chronic the chronic th	Fé	577		
	the U.S. FOIA (6) 16) who proceed the review of the Resident #95 had no NEX FOIA (6) that time, the #95 had not had his/those scheduled day responsible for ensure On 5/29/24 at 9:19 A CNA #3 who stated to give the residents	AM, the surveyor interviewed vided the surveyor with 95's Sheets. A sheets revealed that t received their scheduled confirmed that Resident her scheduled on s, and that she was ring that she was not always able were done.				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING COMPLETE	(X3) DATE SURVEY COMPLETED	
B. WING		
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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLETE CARE AT SHORROCK 75 OLD TOMS RIVER ROAD		
BRICK, NJ 08723		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
many residents and it gets too hectic."  On 5/29/24 at 10:13 AM, the form in the presence of the first of the presence of the first of the presence of the first of the given on the resident's assigned days. The further stated if the first of the surveyor that Resident #64 had not received their scheduled first on Friday for the stated had not received their scheduled first on Friday for the stated had not received their scheduled weekly for Tuesdays and Fridays, but that the facility was often short-staffed, and he/she was "lucky" if they even get one fried the surveyor week.  The surveyor reviewed the medical record of Resident Resident #94.  A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included for the facility with		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315453 B. WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 677 Continued From page 22 F 677 many residents and it gets too hectic." in the On 5/29/24 at 10:13 AM, the presence of the U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged N Ex Order 26. should be given on the resident's assigned days. The further stated if the NJEX OTHER 25.4(1) were not given on the assigned day, they should be given the following day. 8. On 5/20/24 at 11:06 AM, the surveyor observed Resident #109 in bed and observed his/her Were NJ Ex Order 28.4(b)(1) and with a NJ Ex Order 26.4(b)(1) On 5/22/24 at 7:32 AM, the surveyor accompanied by the strong entered Resident #109's room. The confirmed the were NJ Ex Order 26.4(b)(1). The us FOIA (b) (6) stated that the nurses were responsible for NJ Ex Order 26.4(b)(1) and the CNAs were responsible for cleaning them and that they should be checked and cleaned daily. The surveyor reviewed the medical record for Resident #109. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order  $26.4(b)(\overline{1})$  and NJ Ex Order 26.4(b)(1)A review of the most recent comprehensive MDS reflected the resident had dated and required NJ Ex Order NJ Ex Order 26.4(b)(1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 315453 B. WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 677 Continued From page 23 F 677 A review of the ICCP included a focus area dated that the resident was at risk for due to a NJ Ex Order 26.4(b)(1) Interventions included to keep and and NJ Ex Order 26.4(b)(1) after NJ Ex Order 26.4(b)(1) ASAP On 5/29/24 at 10:13 AM, the US FOAM in the s. FOIA (b) (6), and presence of the U.S. FOIA (b) (6) stated that VI Ex Order 25.4(b) care was part of grooming and that CNAs should be checking, NJEXON and cleaning the JJ Ex Order 26.4(b)(1) further stated residents The that if a resident had a diagnoses of CNAs should not , but should still clean them. 9. On 5/21/24 at 11:45 AM, the surveyor observed Resident #16 seated in a chair and observed the resident had a in place . The surveyor observed that to their on both their Resident #16's were NJ Ex Order 26.4(b)( The surveyor reviewed the medical record of Resident #16. A review of the Admission Record face sheet, reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(b) A review of the most recent comprehensive MDS dated , reflected the resident had and was on staff

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315453 R WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 698 Continued From page 26 F 698 week on Mondays, Wednesdays, and Fridays. updated care plan to meet their needs. A PO dated , to monitor Residents #62 and #84 were assessed, (NJ Ex Order 26.4(b)(1 physician orders were obtained and care plans were completed to ensure proper assessment, monitoring, and follow-up as for signs and All Licensed Nurses were reeducated by symptoms of NJ Ex Order 26.4(b)(1) on A PO dated to the Director of Nursing on 6/4/2024 on the every shift for NJ Ex Order 26.4(b)(1 following facility policies: Hemodialysis NJ Ex Order 26.4(b)(1 Access Care and Care Plans, Comprehensive Person-Centered to ensure compliance with the requirement. A review of the comprehensive care plan did not Measures or systematic changes to include a focus area with interventions for ensure that the deficiencies will not recur: dialysis. The Director of Nursing, Assistant Director of Nursing or Designee will On 5/23/24 at 10:45 AM, the surveyor interviewed conduct audits of 2 resident charts who the U.S. FOIA (b) (6) ) who stated are receiving Hemodialysis to ensure that the resident was on and was cleared to they are assessed according to physician as an NJ Ex Order 28.4(b)(1) two to three use the orders, based on the facility policies and stated the resident also weeks ago. The standards of practice every shift. The JJ Ex Order 26.4(b)(1) in their had a that was audits will be conducted weekly for 4 stated there were no weeks, then bi-weekly for 2 months. covered. The The Director of Nursing, Assistant assessments that she needed to do for the or NJ Ex Order 26.4(b)(1) no dressings that were Director of Nursing or Designee will done either. The resident had a communication conduct 2 audits weekly of resident charts record that went with him/her to who are receiving Hemodialysis for 4 and obtained and NJEX The weeks, then bi-weekly for 2 months to stated the U.S. FOIA (b) (6) ensure that residents who are receiving completed the care plans. hemodialysis have a comprehensive, person-centered care plan in place related On 5/23/24 at 10:54 AM, the surveyor interviewed to hemodialysis. who stated for a resident who went Results of all audits will be reviewed at the The facility obtained vital signs prior to Monthly Quality Assurance Meeting and leaving and the center obtained and Quarterly over the duration of the audit

record to communicate with the

anything that occurred at

center

or anything that

The facility used a communication

process to ensure compliance and

reassessment for further action.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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F 698	stated if a resident professional stand the New York keep clear or stated professional was to constitute which was an assistant for fingers or stethose sure functioning, in the notified the physic confirmed there is check that time, the medical record, and using the no physician's ore shift as well as not there should also the should be should	thad a NJ EX Order 26.4(b)(1)  dards of practice was to monitor an and NJ EX Order 26.4(b)(1)  dards of practice was to monitor an and NJ EX Order 26.4(b)(1)  all standards of practice for an eleck NJ EX Order 26.4(b)(1) or was any issues, the nurse cian immediately. The NJ EX Order 26.4(b)(1) or was any issues, the nurse cian immediately. The NJ EX Order 26.4(b)(1) or was any issues, the nurse cian immediately. The NJ EX Order 26.4(b)(1) or was any issues, the nurse cian immediately. The NJ EX Order 26.4(b)(1) or was any issues, the nurse cian immediately. The NJ EX Order 26.4(b)(1) or was any issues, the nurse cian immediately. The NJ EX FOLA(b)(0) as well as a care plan.  SEGUA(b)(0) review Resident #62's and there was lier to check NJ EX ORDER (and NJ EX OR	F	98				

the U.S. FOIA (b) (6)

who stated if a

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	riple construction	(X3	O DATE SURVEY COMPLETED
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F 698	resident had a orders to check it, and there should be should be severy shift. The she was aware there check the resident's well as well as orders. Care  On 5/29/24 at 10:13 presence of the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. Tolar (b) (6), U.S. Tolar (c) the should be assessing regardless if the order sident #84.  A review of the Admireflected the resident with diagnoses which pure with diagnoses which it is following physicial. A PO dated of the following physicial of the following physicial of the following physicial of the following greater than symptoms of A PO dated of the following physicial of the following physicial of the following physicial of the following greater than symptoms of A PO dated of the following physicial of the following greater than of the following greater than of the following physicial of the following greater than of the following greater than of the following greater than of the following physicial of the following greater than of the following physicial of the following greater than of the following physicial of the following greater than of the following physicial of	there should be and if the resident had an acknowledged that ewas no physician's order to and acknowledged that ewas no physician's order to and acknowledged that ewas no physician's order to every shift as plan prior to surveyor inquiry.  AM, the in the FOIA (b) (6)  FOIA (b) (6), and survey that was cleared for use on infirmed that the nurse for substituting and included and included acknowledged that the facility included and the facility inc	F	598		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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COMPLET	E CARE AT SHORROCK				75 OLD TOMS RIVER ROAD		
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F 698	medical record. A revisince should be rotated; che warmth, redness, terminate and or give injections; nee should be rotated; che (warmth, redness, terminate and or since should be rotated; che (warmth, redness, terminate and or since should be rotated; che (warmth, redness, terminate and since should be rotated; che (warmth, redness, te	wiew of the Progress Notes include a Nurse's Note every was monitored.  M, the surveyor interviewed for a resident had an acknowledged that was no physician's order to every shift iry.  AM, the STOA in the every shift iry.	F	698			

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AND DLAN OF CORRECTION IDENTIFICATION NUMBER				SURVEY LETED		
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				75 OLD TOMS RIVER ROAD	1 03/	23/2024
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intervals; do not acce pressure; advise reside tight jewelry or lift head check color and temp the radial pulse of the performing routine cale and check patency of Palpate the site to feestethoscope to hear the blood flow through the medical nurse should medical record every the catheter; condition (interventions if needed during shift; any part of post-dialysis being given post-dialysis.  A review of the facility Comprehensive Personeviewed January 202 comprehensive, personicludes measurable meet the resident's plant functional needs is defor each residentthe person-centered care services that are to be services that are to be services.	dent not to sleep on, wear any objects with access arm; erature of the fingers, and access arm when are and at regular intervals; the site at regular intervals. If the "thrill", or use a ne "whoosh" or bruit" of the access sitethe general document in the resident's shift as follows: location of nof the dressing ed); if dialysis was done of report from dialysis nurse of report from dialysis	F	698			
physical, mental, and NJAC 8:39-27.1 (a) Physician Visits - Rev CFR(s): 483.30(b)(1)-	psychosocial well-being riew Care/Notes/Order -(3)	F	711			7/10/24
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENC' REGULATORY OR L  Continued From page intervals; do not acce pressure; advise resid tight jewelry or lift hea check color and temp the radial pulse of the performing routine ca and check patency of Palpate the site to fee stethoscope to hear ti blood flow through the medical nurse should medical record every the catheter; condition (interventions if neede during shift; any part of post-dialysis being giv post-dialysis being giv post-dialysis.  A review of the facility Comprehensive Persor reviewed January 202 comprehensive, persor includes measurable meet the resident's ph functional needs is de for each residentthe person-centered care services that are to be maintain the resident' physician Visits - Rev CFR(s): 483.30(b)(1)- §483.30(b) Physician	CORRECTION  315453  ROVIDER OR SUPPLIER  E CARE AT SHORROCK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 31 intervals; do not access arm to take blood pressure; advise resident not to sleep on, wear tight jewelry or lift heavy objects with access arm; check color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals. Palpate the site to feel the "thrill", or use a stethoscope to hear the "whoosh" or bruit" of the blood flow through the access sitethe general medical nurse should document in the resident's medical record every shift as follows: location of the catheter; condition of the dressing (interventions if needed); if dialysis was done during shift; any part of report from dialysis nurse post-dialysis being given; observations post-dialysis.  A review of the facility's "Care Plans, Comprehensive Person-Centered" policy dated reviewed January 2024, included a comprehensive Person-centered care plan that includes measurable objectives and timetables to meet the residentthe comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the residentthe comprehensive, person-centered care plan willdescribe the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being  NJAC 8:39-27.1 (a)  Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3)  §483.30(b) Physician Visits	ROVIDER OR SUPPLIER  **E CARE AT SHORROCK**  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 31  intervals; do not access arm to take blood pressure; advise resident not to sleep on, wear tight jewelry or lift heavy objects with access arm; check color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals. Palpate the site to feel the "thrill", or use a stethoscope to hear the "whoosh" or bruit" of the blood flow through the access sitethe general medical nurse should document in the resident's medical record every shift as follows: location of the catheter; condition of the dressing (interventions if needed); if dialysis was done during shift; any part of report from dialysis nurse post-dialysis being given; observations post-dialysis.  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WING  COVIDER OR SUPPLIER  E CARE AT SHORROCK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 31  Intervals; do not access arm to take blood pressure; advise resident not to sleep on, wear tight jewelry or lift heavy objects with access arm; check color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals; and check patency of the site at regular intervals. Palpate the site to feel the "thrill", or use a stethoscope to hear the "whoosh" or bruit" of the blood flow through the access sitethe general medical nurse should document in the resident's medical record every shift as follows: location of the catheter; condition of the dressing (interventions if needed); if dialysis was done during shift; any part of report from dialysis nurse post-dialysis being given; observations post-dialysis being given; observations post-dialysis being given; observations post-dialysis.  A review of the facility's "Care Plans, Comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident the comprehensive, person-centered care plan willdescribe the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being  NJAC 8:39-27.1 (a) Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3)  §483.30(b) Physician Visits	ROVIDER OR SUPPLIER  E CARE AT SHORROCK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 31 Intervals; do not access arm to take blood perssure; advise resident not to sleep on, wear tight jewelry or lift heavy objects with access arm; check color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals; and check patency of the site at regular intervals. 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PRINTED: 11/07/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X:	(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			C <b>05/29/2024</b>	
	ROVIDER OR SUPPLIER	ск		STREET ADDRESS, CITY, STATE, ZIP C 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	ODE	00,20,202	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 711	of care, including neach visit required section;  §483.30(b)(2) Writnotes at each visit; §483.30(b)(3) Signexception of influer vaccines, which maphysician-approver assessment for contract to the complaint NJ #: 1  Based on interview documents, it was failed to ensure that physician wrote an Progress Notes at deficient practice were idents reviewed #147), and eviden  The surveyor reviet for Resident #147.  A review of the Adradmission summar was admitted to the included, but not lin  NJ Ex Order 26	ew the resident's total program nedications and treatments, at by paragraph (c) of this  e, sign, and date progress and  and date all orders with the nza and pneumococcal ay be administered per difficulty policy after an intraindications.  NT is not met as evidenced  61027  and review of pertinent facility determined that the facility determined that the facility at the resident's primary disigned their Physician's the time of each visit. This was identified for 1 of 3 for closed records (Resident ced by the following:  wed the closed medical record  mission Record face sheet (an ry) reflected that Resident #147 et facility with diagnosis that mited to, INTEX Order 26.4(b)(1)	F7	F711 Physician Visits - R Care/Notes/Order.  Resident affected by deficient of the facility failed to en resident's primary physicians signed their Physician's Protective was identified for the time of each visit. This practice was identified for reviewed for closed records #147).Resident #147 was completed by the deficient protection of the facility on the latest of the latest	ent practice: isure that the n wrote and ogress Notes a deficient 1 of 3 residents is (Resident discharged to with who could be actice: potential to be be sidents affected ere reviewed	5	

Facility ID: NJ656003

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315453 R WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 711 Continued From page 33 F 711 The U.S. FOIA (b)  $\overline{(6)}$ the following had a "LATE ENTRY", a designation and NJ Ex Order 26.4(b) which indicated the notes were not written on the effective date (Date of service): were reeducated by the Regional Licensed Nursing Home Administrator on 1. PPN with an effective date of 6/4/2024 on the facility policy titled but with a created date of Physician Visits. All physicians were 2. PPN with an effective date of reeducated on 6/4/2024 by the Licensed a created date of NJ Ex Order 2 Nursing Home Administrator and provided 3. PPN with an effective date of a copy of the facility policy titled Physician a created date of NJEX OTHER at 12:33:29. 4. PPN with an effective date of , but with a created date of at 12:32:56. Measures or systematic changes to 5. PPN with an effective date of Next order 25 , but with ensure that the deficiencies will not a created date of at 12:32:20. reoccur: The Licensed Nursing Home On 5/28/24 at 10:16 AM, the surveyor interviewed Administrator, Director of Nursing or the U.S. FOIA (b) (6) Designee will conduct 4 audits on reviewed the resident's eMR and confirmed the residents charts for timely completed above entries were not entered at the time of physician s progress notes weekly for 4 visit. weeks, then 2x monthly for 2 months to ensure that primary physicians wrote and On 5/28/24 at 1:58 PM, in the presence of the signed their Physician's Progress Notes at survey team, the surveyor informed the the time of each visit as required. Results FOIA (b) (6) of the audits will be reviewed at the us. FOIA (b) (6), and Monthly Quality Assurance Meeting and U.S. FOIA (b) (6) the concern that physician Quarterly over the duration of the audit progress notes were entered days after the process to ensure compliance and patient visit. reassessed for further action. On 5/29/24 at 11:23 AM, the in the u.s. FOIA (b) (6), and presence of the U.S. FOIA (b) (6) confirmed that the physician did not document and sign the PPN at the time of the physician visit. A review of the facility's "Physician Visits" policy, last reviewed January 2024, included [ ...] 5. The Attending Physician must perform relevant tasks

at the time of each visit, including a review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			1	C <b>29/2024</b>	
	ROVIDER OR SUPPLIER	<b>.</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723		OLD TOMS RIVER ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 711	documentation.  NJAC 8:39-23.2(b)	am of care and appropriate	F	711				
F 712 SS=D	CFR(s): 483.30(c)(1)- §483.30(c) Frequence §483.30(c)(1) The resphysician at least one 90 days after admissi 60 thereafter. §483.30(c)(2) A physimely if it occurs not date the visit was req §483.30(c)(3) Except (c)(4) and (f) of this so visits must be made to see the control of the control	y of physician visits sidents must be seen by a see every 30 days for the first ion, and at least once every dician visit is considered later than 10 days after the uired.  as provided in paragraphs ection, all required physician by the physician personally.  Experimental visit, may resonal visits by the physician ion assistant, nurse nurse specialist in agraph (e) of this section.	F	712	F712 Physician Visits Frequency/Timeliness/Alt NPP		7/10/24	
	documents, it was de failed to ensure that t supervising the care of face-to-face visits and	nd review of pertinent facility termined that the facility he physician responsible for of residents conducted d wrote progress notes at This deficient practice was			Resident affected by deficient practice: The facility failed to ensure that the physician responsible for supervising the care of residents conducted face-to-fact visits and wrote progress notes at least every 30 days. This deficient practice were	ne ce t		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			(	С
		315453	B. WING			05/	29/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	E CARE AT SHORROCK	(			5 OLD TOMS RIVER ROAD		
				В	BRICK, NJ 08723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 712	identified for 1 of 3 re records (Resident #1: the following:	e 35 sidents reviewed for closed 51) and was evidenced by ed the closed medical record	F	712	identified for 1 of 3 residents reviewed closed records (Resident #151). Resident #151 has been discharged from the facility.  Identify those individuals who could be affected by the deficient practice:	om	
	admission summary) was admitted to the faincluded, but not limit NJ Ex Order 26.4(b)(1) . According to t Resident #151 was in	Ex Order 26.4(b)(1) he Admission Record, the facility for a total of			All residents have the potential to be affected.  What corrective action will be accomplished for those residents affect by the deficient practice:  All resident charts were reviewed and updated to ensure physician visits are occurring at appropriate intervals	ted	
	U.S. FOIA (b) (6) assessments; however able to locate any phy Resident #151.  On 5/28/24 at 10:16 Athe U.S. FOIA (b) stated that it was the physician examined a and every 30 days. T	), the surveyor located  ) handwritten  er, the surveyor was not ysician assessments for  AM, the surveyor interviewed			according to the facility policy titled Physician Visits. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were reeducated by the Regional Licensed Nursing Home Administrator 6/4/2024 on the facility policy titled Physician Visits. All physicians were reeducated by the Licensed Nursing Home Administrator on 6/4/2024 and provided a copy of the facility policy title Physician Visits.		
	On 5/28/24 at 1:58 Pl survey team, the surv U.S. FOIA (b) (6) the co	M, in the presence of the veyor informed the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and oncern that Resident #151 umented physician visits or			Measures or systematic changes to ensure that the deficiencies will not recommend the Licensed Nursing Home Administrator, Director of Nursing or Designee will conduct audits of 2 residents weekly for 4 weeks, then audits 2 resident charts bi-weekly for 2 month to ensure that primary physicians conducted and documented face-to-factivists in accordance with the facility s	ent of ıs	

Facility ID: NJ656003

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315453	B. WING				C
NAME OF DE	ROVIDER OR SUPPLIER	010400		٥.	TREET ADDRESS, CITY, STATE, ZIP CODE	05/	29/2024
	E CARE AT SHORROCK		75 OLD TOMS RIVER ROAD BRICK, NJ 08723		5 OLD TOMS RIVER ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 712	On 5/29/24 at 11:123 that there were no ph record.  A review of the facility last reviewed January Attending Physician releast once every thirty (90) days following the then at least every six NJAC 8:39-11.2(b)	AM, the confirmed ysician assessments on y's "Physician Visits" policy, y 2024, included [] 2. The nust visit his/her patients at y (30) days for the first ninety e resident's admission, and ty (60) days thereafter [].		712	Physician Visit policy. Results of all audits will be reviewed at Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessment for further action.	d	7/40/04
F 725 SS=E	§483.35(a) Sufficient The facility must have the appropriate comp provide nursing and r resident safety and at practicable physical, r well-being of each res resident assessments and considering the r diagnoses of the facil accordance with the f at §483.70(e).  §483.35(a)(1) The fac by sufficient numbers types of personnel on nursing care to all res resident care plans: (i) Except when waive this section, licensed	Staff.  Staff.	F	725			7/10/24

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-COMPLETED AND PLAN OF CORRECTION A. BUILDING 315453 R WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 725 Continued From page 37 F 725 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced Complaint NJ #: 157735; 160630; 164199; F725 Sufficient Nursing Staff 170619; 172027 Residents affected by deficient practice: Based on observation, interview, and review of The facility failed to ensure sufficient and pertinent facility documentation, it was competent staff were available to a.) provide appropriate NJ Ex Order 26.4(b)(1) care to determined that the facility failed to ensure sufficient and competent staff were available to residents for 5 of 8 residents a.) provide appropriate NJ Ex Order 28.4(b)(1) care to (Resident # 94, #16, #8, #109, and #137) residents for 5 of 8 residents and b.) ensure residents received as scheduled for 2 of 2 residents (Resident # 94, #16, #8, #109, and #137) and b.) ensure residents received NEX OTHER 25.4(1) as scheduled (Resident #95 and #94). for 2 of 2 residents (Resident #95 and #94) reviewed for sufficient staffing, and was Identify those individuals who could be evidenced by the following: affected by the deficient practice: All residents have the potential to be Refer to F677 affected 1. On 5/20/24 at 11:41 AM, the surveyor observed What corrective action will be Resident #94 in bed with their eyes open, accomplished for those residents affected . The Resident's Representative (RR by the deficient practice: #1) informed the surveyor that Resident #94 had All residents were monitored for any not received care that morning which included adverse effects with none noted. NJ Ex Order 28.4(b)(1) care, and that they were still A facility-wide assessment was done to from last night. At that time, ensure that all patients had their most recent scheduled wexage and appropriate Resident #94 nodded in agreement. NJ Ex Order 26.4(b)(1) care was completed. On 5/20/24 at 11:52 AM, the surveyor found Residents #94, #16, #8, #109, and #137 Resident #94's Certified Nursing Assistant (CNA were provided with the appropriate NJ Ex Order 26.4(b)(1) care and residents #95 and #1) who confirmed she was the resident's aide for #94 received NJEX Order 25.4(t) per their the day, and stated she had provided NJ Ex Order 28.4(b)(1) care earlier that shift. The surveyor preferences and scheduled N Ex Order 26. days. The U.S. FOIA (b) (6) U.S. FOIA (b) (6) accompanied by CNA #1, entered Resident #94's

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	ROVIDER OR SUPPLIER	ĸ		STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	1 33	20/2027	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 725	phone interview with assigned to Residen PM to 7:00 AM (11-7). Review of the CNA at the unit had a censul assigned aides. CN 18 residents on that On 5/24/24 at 10:17 the U.S. FOIA (b) (f) acking the provided exhift and twice on the NEX Order 26.4(b) (f) rounds 12:00 AM and 2:00 AM and 2:00 AM and 7:00 AM On 5/29/24 at 10:13 presence of the U.S. FOIA (b) (6) acking the provided exhibit and twice on the Should be provided exhibit and twice on the U.S. FOIA (b) (6) acking the provided exhibit and twice on the Weelchair. The Resident's clothing wheelchair with a CNA surveyor observed a the room. CNA #3 acting the complex of the provided exhibit and the complex of the complex o	AM, the surveyor attempted a the CNA #2 who was at #16 on the served and the CNA #2 who was at #16 on the served and the control of shift with no answer.  Assignment sheet revealed as of 52 Residents with three A #2 had an assignment of shift.  AM, the surveyor interviewed med that shift. The first should be done between AM, and then again between AM, and then again between AM, and then again between AM.  AM, the served in the servery two hours.  AM, the surveyor attempted a sident's Representative (RR atturday he/she observed the as NJ Ex Order 26.4(b)(1), and Order 26.4(b)(1) under  AM, the surveyor observed	F 72!	policy Staffing to accommodat needs. Results of all interviews/audits or reviewed at the Monthly Quality Assurance Meeting and Quarte duration of the audit process to compliance and reassessment action.	will be  rrly over the  ensure		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 725	and stated, "n CNA #3 confirmed care provided for R On 5/22/24 at 7:41 rounds, the surveyor an NJ Ex Order 26.4(b)(with N	were all SUEX Order 26.4(b)(1) that was her first SUEX Order 26.4(b)(1) esident #8 for that day.  AM, during SUEX Order 26.4(b)(1) or observed the resident with 1) with SUEX Order 26.4(b)(1) 4(b)(1) the SUEX Order 26.4(b)(1) 4(b)(1) the SUEX Order 26.4(b)(1) 4(b)(1) the SUEX Order 26.4(b)(1) AM, the surveyor attempted a h CNA #4 who was assigned the SUEX ORDER 26.4(b)(1) 11-7 shift with no  assignment sheet revealed us of 52 Residents with three NA #4 had an assignment of t shift.  7 AM, the surveyor interviewed rmed that SUEX Order 26.4(b)(1) care every two hours on the day the night shift. The first is should be done between AM, and then again between	F 725		

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F 725	increased the ch	The <sup>US.FOIA</sup> acknowledged <sup>26.4(b)(1)</sup> inside an <sup>UJ Ex Order 26.4(b)(1)</sup> nance of <sup>NJ Ex Order 26.4(b)(1)</sup> .	F 7:	25				
	did not receive their selections and that the Tuesday were schedard Fridays, but that short-staffed, and he	#95 who stated that he/she scheduled NEXOGO On Friday ir last was on sident #95 stated that their uled weekly for Tuesdays						
	CNA #5 who informe days were lis assignments. CNA # was done, th	AM, the surveyor interviewed d the surveyor that resident ted on each of the CNA's further stated that when a e CNAs signed the Sheet which was kept in a						
	A review of the revealed that Reside on New York or a review of the revi	er 25.4b1 NEX Order 25.4 Sheet  nt #95 had not received their						
	the us Fola (b) (6) who cor had not been signed had not received thei further stated that sh- ensuring all residents	AM, the surveyor interviewed offirmed that the indicating that Resident #95 r Nes Tolar (1) (6) e was responsible for a received Nes Tolar (1) (6) received Nes Tolar (1) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7						
	CNA #3 who stated to give the residents	M, the surveyor interviewed hat she was not always able were assigned on their assigned e sometimes she had "too						

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315453	B. WING		C 05/29/2024
	ROVIDER OR SUPPLIER	K	7	STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	1 00/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 725	be given on the resident further stated in on the assigned day following day.  6. On 5/20/24 at 11 representative (RR # the resident had not was on Tues stated that Resident scheduled weekly for that the facility was on the facility was on the facility was on Tues stated that Resident scheduled weekly for that the facility was on the facility w	AM, the Serond in the should dent's assigned days. The fine surveyor that received their scheduled were received one  AM, the surveyor interviewed at they even received one  AM, the surveyor interviewed and the surveyor that the swere listed on each of the CNA #5 further stated that done, the CNAs signed the Sheet which was kept in a  Ewood Serond Scheduled were sheet and not received their sheet do not been signed indicating and not received their specific sheet which were sheet do not received their sheet do not	F 725		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	. ,	OMPLETED
		315453	B. WING _			C <b>05/29/2024</b>
	ROVIDER OR SUPPLIER	K		STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	<b>'</b>	00/23/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 725	On 5/29/24 at 9:19 A CNA #3 who stated to give residents days because many residents and On 5/29/24 at 10:13 presence of the U.S. FOIA (b) (6) acknown be given on the resident further stated if on the assigned day following day.  A review of the facility September 2023, incompetency necessary services for all resident care and far numbers and skills resident care	AM, the surveyor interviewed that she was not always able on their assigned on their assigned to sometimes she had "too it gets too hectic."  AM, the surveyor interviewed that she was not always able on their assigned too it gets too hectic."  AM, the surveyor interviewed that she was not always able on their assigned too it gets too hectic."  AM, the surveyor interviewed that she was not always able on the should she was should dent's assigned days. The should be given the sty's "Staffing" policy updated cluded our facility provides for staff with the skills and any to provide care and the she will be seen that she will be seen that she will be provided with care, the same propriate to their ability to carry out	F 7	25		
F 812 SS=E		Store/Prepare/Serve-Sanitary (2)	F 8	12		7/10/24

I . ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED		
		315453	B. WING				C / <b>29/2024</b>	
	ROVIDER OR SUPPLIER	<		7	STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	1 03/	23/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 812	approved or conside state or local authorit (i) This may include if from local producers and local laws or reg (ii) This provision do facilities from using p gardens, subject to a safe growing and food (iii) This provision do from consuming food (iii) This provision do from consuming food S483.60(i)(2) - Store serve food in accord standards for food set This REQUIREMENT by:  Based on observation determined that the fipotentially hazardous illness; b.) maintain routting board in a magrowth; c.) ensure was a manner to prevent maintain storage are This deficient practic following:  On 5/21/24 at 8:40 A	re food from sources red satisfactory by federal, ties. Food items obtained directly subject to applicable State ulations. For a prohibit or prevent produce grown in facility compliance with applicable ad-handling practices. For a preclude residents are not procured by the facility. For a prepare, distribute and ance with professional procured by the facility. For and interview, it was facility failed to a.) store is foods to prevent food-borne multiuse food-contact surface anner to prevent microbial growth; d.) as in a sanitary manner. For a procured by the surveyor toured the multiuse food-code by the surveyor toured t	F	812	F812-Food Procurement  Residents affected by deficient practice. The facility failed to a.) store potentially hazardous foods to prevent food-borne illness; b.) maintain multiuse food-cont surface cutting board in a manner to prevent microbial growth; c.) ensure washed cookware was dried in a manner to prevent microbial growth; d.) mainta storage areas in a sanitary manner.  Identify those individuals who could be	/ e act ner in		
	kitchen with the U.S and observed the fol				affected by the deficient practice: All residents have the potential to be affected.			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR MC	<i>).</i> 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			1	C / <b>29/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	25/2024
					OLD TOMS RIVER ROAD		
COMPLET	E CARE AT SHORROCK	(			RICK, NJ 08723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	o 46		040			
ГОІZ	, ,		F 8	812	NAM		
		ive stacks of twenty-four			What corrective action will be		
		ream cups, and a stack of			accomplished for those residents affec	ted	
		th a box of oriental blend			by the deficient practice:		
		n the floor. The stated			All residents were monitored for any		
		e just delivered and the			adverse effects with none noted.		
		eling the boxes before			The five stacks of twenty-four cases in		
	transferring them into				total of ice cream cups, and a stack of		
		should not be stored or come			frozen vegetables with a box of orienta		
	in direct contact with	the noor.			blend vegetables were immediately pic		
	O la the well in face	the view ature eventains			up from the floor, properly labeled, and		
		zer, the vinyl strip curtains			stored properly in the walk-in freezer o	n	
		ce to the freezer, two curtain			5/21/2024.		
		the middle of the doorway.			The two curtain etrine in the middle of t	·h o	
	_ ·	ct the inside of the freezer			The two curtain strips in the middle of t	ne	
		ticles as well as keep the			doorway were replaced on 6/3/2024 to ensure that the walk-in freezer maintain		
		g the freezer when the door ezer was currently at 25				115	
	degrees Fahrenheit.				the proper temperature.		
		eased from the door being			The layer of frost that covered the		
	opened for the delive				identified boxes was removed on		
		1103.			5/21/2024 with no further issues.		
	3 On the shelves in t	the walk-in freezer, the			0/21/2024 With no farther issues.		
		in a thick layer of frost which			The built-up ice on the condenser and	the	
	included the following				rods of ice on the top shelf under the		
	identified for the surv				condenser unit were removed on		
		nree liquid coffee containers;			5/21/2024 with no further issues.		
		coli spears; health shakes;			6,2 1,202 1 11lll 11le 14ll 11le 1 lee 1 lee 1		
		uffed cabbage. The			The built-up ice on the insider of the ice	Э	
		ce should not be covering			cream chest was removed on 5/21/202		
		used by the door being			with no further issues.		
	opened for deliveries	-					
	•				The dented six-pound four-ounce can	of	
	4. In the walk-in freez	zer, the condenser unit had a			cut sweet potatoes was removed from		
	build-up of ice, and th				active inventory area on 5/21/2024. An		
	condenser unit conta				audit of the dry storage area was		
	approximately four to			completed on 5/21/2024 and ensured t	hat		
	acknowledged t	he unit and shelves should			there were no other dented cans in the		
	not have ice buildup.				active inventory area.		

Facility ID: NJ656003

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315453 R WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 812 Continued From page 47 F 812 5. The ice cream chest had a build up of ice on All cutting boards identified as pitted, with the inside. black and yellowish discoloration were taken out of service and replaced with 6. In dry storage ,one six-pound four-ounce can new cutting boards on 5/21/2024. of cut sweet potatoes dented was in active inventory. The two four-inch half pans and the five four-inch plastic half pans that were wet 7. On a storage shelf, one large brown cutting nesting were removed, washed, and board deeply pitted with black discoloration; one properly placed to dry on 5/21/2024. The large light blue cutting board pitted and yellowish plastic half pan with brownish debris and discoloration in grooves; one large brown cutting missing a corner of the plastic was board pitted; one large yellow cutting board pitted discarded on 5/21/2024. and discolored black; two large red cutting boards pitted; and one large green cutting board pitted All dietary staff were re-educated on with yellow discoloration in the grooves. The 6/4/2024 by the Licensed Nursing Home stated cutting boards were replaced every Administrator on the following policies: quarter or six months and acknowledged those Dish Washing and Pot Washing, Kitchen cutting boards needed to be replaced. The Equipment, Receiving and Inspecting stated the grooves could cause bacterial growth. Guidelines, Cutting Board, Dented Can. Measures or systemic changes to ensure 8. On the storage rack, two four-inch half pans were wet nesting and five four-inch plastic half that the deficiencies will not recur: pans were wet nesting. One of the plastic half The Dining Service Director/Designee will pans had brownish debris in it and was missing a conduct one audit weekly for 4 weeks, corner of the plastic. The confirmed the then 2x monthly for 2 months. The audits broken plastic half pan should not be in use, and will ensure that all items are properly pans should not be wet nested. stored and not directly on the floor, no ice buildup is present in the walk-in freezer, On 5/22/24 at 8:30 AM, the U.S. FOIA (b) (6) fridge or ice cream chest, no dented cans are in the active inventory area, all cutting stated the walk-in freezer repair company was at the facility boards are in good condition to be used, vesterday afternoon who replaced the motor on no wet nesting is present, and no debris the freezer unit which was now operating or damage is present on any pans. properly. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting On 5/29/24 at 10:13 AM, the in the and Quarterly over the duration of the presence of the U.S. FOIA (b) (6) audit process to ensure compliance and

U.S. FOIA (b) (6) and U.S. FOIA (b) (6)

acknowledged the surveyor's concerns.

reassessed for further action.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315453	B. WING				0
NAME OF D	201/IDED OD OUDDUED	010400	D: 1110 _		TREET ADDRESS SITY STATE ZID SODE	05/	29/2024
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	E CARE AT SHORROCK				5 OLD TOMS RIVER ROAD		
				Е	BRICK, NJ 08723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	÷ 48	F	812			
	Washing and Pot Waitems must be air drie sanitizer to break downesting. Note: nesting pans are placed toget to become trapped ar This can cause bacteclean pans  A review of the facility Equipment" policy incis inspected daily by famintenance during recommendations fro companies during visual A review of the facility "Receiving and Insperincludedproduct pla	wn any biofilms and avoid g is when two or more wet ther. This causes moisture and does not allow it to dry. rial growth and contaminate  r provided undated "Kitchen cluded all kitchen equipment food service director, by ounds and with m outside service its					
	floor A review of the undate "Cutting Board Policy needed.  A review of the undate "Dented Can Policy" in Director or designees delivery to ensure the	ed facility provided policy " includedreplace when  ed facility provided policy ncludedthe Food Service will spot check all cans upon ere are no dents, bulges, or					
F 814 SS=E		entified to not be in good ed to the designated dented d Refuse Properly	F	814			7/10/24

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	l' '		(X3) DATE S	
		315453	B. WING _			05/2	29/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	)E	1 00.12	10/2024
COMPLET	E CARE AT SHORROCK			BRICK, NJ 08723			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	<b>I</b>	(X5) COMPLETION DATE
F 814	Continued From page CFR(s): 483.60(i)(4)	<del>2</del> 49	F 8	14			
	properly. This REQUIREMENT by: Based on observatio determined that the fadispose and maintain dumpster areas. This	s deficient practice was arbage dumpsters, and was		F814 □ Dispose Garbage Pr Residents affected by deficien The facility failed to properly of maintain cardboard waste in a areas. This deficient practice identified for 1 of 3 garbage d	nt practice dispose ar dumpster was	nd	
	garbage compactor at The surveyor observe to be overfilled with in prevented the lid from surrounding the dump cardboxes surrounding dumpster area appropheight, as well as inta fire zone of the facility stated the cardboard twice a week, and too be around the dump maintained in a Con 5/28/24 at 8:53 Al the U.S. FOIA (b) garbage compactor word Tuesday, and cardbo Monday and Friday.	observed the facility's nd cardboard dumpster. The detail the cardboard dumpster at the cardboard boxes that in closing. The area poster had piles of intacting the side walk of the eximately four to five feet in act cardboard boxes in the parking lot. The dumpster was disposed of day was a delivery day. The he cardboard boxes should mpster area, that it was not a sanitary manner.  My the surveyor interviwed (6)  Who stated the vas collected every other ard was collected every stated he did not		Identify those individuals who affected by the deficient pract All residents have the potential affected.  What corrective action will be accomplished for those reside by the deficient practice: All residents were monitored adverse effects with none not The cardboard dumpster was allow the lid to be completely all cardboard surrounding the the sidewalk, and in the fire z properly cleaned and discard 5/21/2024.  All dietary, housekeeping, and maintenance staff were re-ed 6/4/2024 by the Licensed Nur Administrator on the following Garbage and Trash Disposal that facility properly dispose a cardboard waste in the dump	tice: ial to be ents affect for any ted. s emptied to closed, are d dumpster cone was led on d ducated on rsing Hom g policy: to ensure and mainta	ted  to nd er,	
	Based on observation determined that the far dispose and maintain dumpster areas. This identified for 1 of 3 gas evidenced by the following at our of the k AM, the surveyor accomparts of the surveyor observed to be overfilled with in prevented the lid from surrounding the dump cardboxes surrounding dumpster area appropriately as well as intending the cardboard twice a week, and too acknowledged to the cardboard twice a week, and too acknowledged to the prevented the dump to the dump to the facility stated the cardboard twice a week, and too acknowledged to the prevented the dump to the facility stated the cardboard twice a week, and too acknowledged to the prevented the dump to the facility stated the cardboard the facility stated the facility stat	acility failed to properly cardboard waste in a deficient practice was arbage dumpsters, and was owing:  itchen on 5/21/24 at 8:40 companied by the some standard dumpster. The deficient cardboard dumpster area of the cardboard dumpster and the cardboard boxes that a closing. The area coster had piles of intact and the side walk of the similar to five feet in act cardboard boxes in the cyparking lot. The standard boxes in the cyparking lot. The standard boxes should mpster was disposed of day was a delivery day. The he cardboard boxes should mpster area, that it was not a sanitary manner.  My the surveyor interviwed (6) who stated the was collected every other ard was collected every		Residents affected by deficient The facility failed to properly of maintain cardboard waste in a areas. This deficient practice identified for 1 of 3 garbage of lidentify those individuals who affected by the deficient practice. All residents have the potential affected.  What corrective action will be accomplished for those reside by the deficient practice: All residents were monitored adverse effects with none not The cardboard dumpster was allow the lid to be completely all cardboard surrounding the the sidewalk, and in the fire z properly cleaned and discard 5/21/2024. All dietary, housekeeping, and maintenance staff were re-ed 6/4/2024 by the Licensed Nur Administrator on the following Garbage and Trash Disposal that facility properly dispose a	nt practice dispose ar dumpster was dumpsters. It could be tice: it is a to be ents affect for any ted. It is emptied to closed, are dumpsters led on adducated on rsing Hom g policy: to ensure and maintaister areas	ted to nd er,	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		E SURVEY IPLETED
		315453	B. WING		0,	C 5/ <b>29/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		312312024
				75 OLD TOMS RIVER ROAD		
COMPLET	E CARE AT SHORROC	K		BRICK, NJ 08723		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
F 814			F 814	4		
	already cleaned the	area. At that time, the		ensure that the deficiencies will no	ot recur:	
	surveyor showed the	a picture of the area at		The Dining Service Director/Design	gnee will	
	the time of observati	on, and the <sup>us.fo</sup> confirmed		conduct daily audits for 7 days, th	en two	
	the condition of the a	area was unacceptable. The		audits weekly for 3 weeks, then to	vo audits	
	stated the boxes	that were identified still		2x monthly for 2 months.		
		n the nursing department as		Results of audit will be reviewed a		
	· ·	he boxes should have been		Monthly Quality Assurance Meeting	-	
	broken down and no	t left intact.		Quarterly Meetings over the durate the audit process to ensure comp		
	On 5/29/24 at 10:13	AM, the U.S. FOIA (b) (6)		and reassessed for further action.		
		in the presence of				
	the U.S. FOIA (b)	(6) ), U.S. FOIA (b) (6)				
		survey team stated it was				
		the cardboard dumpster was				
		boxes could be stored next				
	to the dumpster. At	that time, the surveyor picture of the dumpster area				
		ation and asked if the area				
		cceptable condition, and the				
	did not respon					
	A review of the unda	ted facility provided "Garbage				
		Policy" included the Dining				
	Services Director co	ordinates with the Directors				
	of Maintenance and	Housekeeping to ensure that				
	the area surrounding	the exterior dumpster area				
	is maintained in a ma	anner free of rubbish or other				
		nd other recycling dumpsters				
		naintained: dumpster door or				
		all times when not in use; all				
	•	breakdown cardboard				
		e; and all boxes should be				
		ng dumpster flattened as to				
		al space. If cardboard				
		k cardboard on concrete				
		il emptied; area around				
		nain clean and free from				
		impster or trash compactor				
	issues to maintenand	ce immediately.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315453	B. WING				C <b>29/2024</b>
	ROVIDER OR SUPPLIER	(	1	7	TREET ADDRESS, CITY, STATE, ZIP CODE 5 OLD TOMS RIVER ROAD BRICK, NJ 08723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 814	Continued From page	<del>2</del> 51	F	814			
F 880 SS=E	NJAC 8:39-19.3(a); 1 Infection Prevention 8 CFR(s): 483.80(a)(1)	& Control	F	880			7/10/24
	development and trar diseases and infection §483.80(a) Infection program.  The facility must esta and control program (a minimum, the follow §483.80(a)(1) A systereporting, investigating and communicable distaff, volunteers, visit providing services un arrangement based us conducted according accepted national statistation (i) A system of surveil possible communicable infections before they persons in the facility (ii) When and to whor	blish and maintain an and control program a safe, sanitary and ment and to help prevent the assission of communicable ans.  brevention and control blish an infection prevention (IPCP) that must include, at ving elements:  been for preventing, identifying, and controlling infections seases for all residents, ors, and other individuals der a contractual upon the facility assessment to §483.70(e) and following and order, which must include, and order and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315453	B. WING		C <b>05/29/2024</b>
	ROVIDER OR SUPPLIER	СК	7:	TREET ADDRESS, CITY, STATE, ZIP CODE 5 OLD TOMS RIVER ROAD RICK, NJ 08723	00/23/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE.
F 880	reported; (iii) Standard and tr to be followed to pr (iv)When and how i resident; including I (A) The type and do depending upon the involved, and (B) A requirement the least restrictive posicircumstances. (v) The circumstance must prohibit emploidisease or infected contact with resider contact will transmi (vi)The hand hygier by staff involved in §483.80(a)(4) A systidentified under the corrective actions to §483.80(e) Linens. Personnel must han transport linens so infection. §483.80(f) Annual r The facility will concurred IPCP and update the This REQUIREMEN by: Based on observate pertinent facility faile standards of practice ensure appropriate	ansmission-based precautions event spread of infections; solation should be used for a put not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.  Stem for recording incidents facility's IPCP and the taken by the facility.	F 880	F880 - Infection Prevention & Control  Residents affected by deficient practice  " The facility failed to maintain infect control standards of practice and	

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X3) DATE (X4) MULTIPLE CONSTRUCTION (X4) DATE (X5) DATE (X6) DATE		SURVEY PLETED				
		315453	B. WING _				C <b>29/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				75	5 OLD TOMS RIVER ROAD		
COMPLET	E CARE AT SHORROC	К		В	RICK, NJ 08723		
(X4) ID	SLIMMARYS	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 880	Continued From pag	ne 53	F	880			
		nfection control practices			procedures to a.) ensure appropriate h	and	
		1 of 1 Resident (Resident			hygiene was performed during lunch m		
		g NJ Ex Order 21 treatments and c.)			in 2 of 5 dining areas; b.) ensure	.oui	
		and hygiene practices during			appropriate infection control practices		
		f 7 residents (Resident #8)			were maintained for 1 of 1 Resident		
	reviewed for Activitie	es of Daily Living (ADLs). The			(Resident #16) observed during NJ EX Order 2	İ	
	evidence was as foll	ows:			treatments and c.) follow appropriate h	and	
					hygiene practices during resident care		
					1 of 7 residents (Resident #8) reviewe	t	
		11:35 AM to 11:48 AM, the			for Activities of Daily Living (ADLs).		
	1	lining in the Meadows Unit.					
	_	lunch trays, the Unit			Identify those individuals who could be affected by the deficient practice:		
		Practical Nurse (UM/LPN #1)  ng alcohol based hand rub			" All residents have the potential to	he	
		e food truck that contained			affected.	DC	
	resident lunch trays.						
	,				What corrective action will be		
	During tray pass, a l	_icensed Practical Nurse			accomplished for those residents affect	ted	
	(LPN #1) and Activit	y Aide (AA #1) were each			by the deficient practice:		
	observed being hand	ded a tray by UM/LPN #1.			" All residents who consumed meal	s in	
		vere observed placing the tray			the dining areas were monitored for ar	y	
	_	ated resident. LPN #1 and AA			adverse effects with none noted.		
	1	cover each resident's plate,			" Residents #16 and #8 were monit		
	I .	ensils to cut food, then			for any adverse effects with none note		
	· ·	ded to obtain another			" Licensed Practical Nurse (LPN #1		
	_	ut performing hand hygiene. f the meal observation, staff			Activity Aide (AA #1), Restorative Aide #1) and (CNA#3) were re-educated an		
	_	erforming hand hygiene in			completed a Hand Hygiene Competen		
	between each tray p				by the Director of Nursing on 5/29/202	•	
					" Licensed Practical Nurse (LPN #2		
	On 5/20/24 from 11:	52 AM to 12:21 PM, the			was reeducated by the Director of Nur	•	
		lining in the Main Dining			on 5/29/2024 on proper disinfecting of		
	Room prior to meal	service, hand hygiene was			supplies and tools, such as scissors ar	nd	
	· •	residents seated in the			markers post completion of skin		
		elivered to the residents by			treatments and to only bring in the		
	_	ach table. The surveyor			amounts supplies required for the		
		e Aide (RA #1) assist a			treatment.		
		neir utensils to cut their meal,			" All Certified Nursing Assistants,		
	and then proceeded	to nour coffee and onen	1	- 1	Licensed Practical Nurses and		1

Facility ID: NJ656003

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315453	B. WING				C / <b>29/2024</b>	
NAME OF D	ROVIDER OR SUPPLIER	0.0.00		97	TREET ADDRESS, CITY, STATE, ZIP CODE	05	129/2024	
TVAINE OF T	TO VIDER OR OUT FIER							
COMPLET	E CARE AT SHORROCK	ζ.			5 OLD TOMS RIVER ROAD RICK, NJ 08723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880	Continued From page	e 54	F8	380				
	sweetener packages. additional residents p of cutting residents' m without performing had on 5/20/24 at 12:27 FAA #1 who stated tha "as needed" between deemed necessary. Was required after trainot necessarily.  On 5/20/24 at 12:34 FLPN #1 who confirme required after every onecessary	RA #1 continued to erforming the same process heals and serving coffee and hygiene.  PM, the surveyor interviewed thand hygiene was required every couple residents or When asked if hand hygiene y contact AA #1 responded,  PM, the surveyor interviewed and that hand hygiene was couple residents and was not a tray contact.  PM, the surveyor interviewed and that there was no encygiene in between residents and touching food. When con should be expected after this is, UM/LPN #1 stated that  PM, the surveyor interviewed and hygiene who explained to be completed as ands were visibly dirty. RA ot expected between every			Registered Nurses were reeducated or 6/4/2024 by the Director of Nursing on facility policy for Wound Care clinical protocol, Hand Hygiene and the importance of disinfecting the surface to be used, maintaining a clean field, providing a protective barrier, and washing and drying hands thoroughly.  Measures or systemic changes to ensuthat the deficiencies will not reoccur:  "The DON/Unit Manger/Designee viconduct audits of 4 nurses for competency of wound care procedure at staff members for Hand Hygiene. Auwill be completed weekly X 4 weeks the monthly x 2 months. Results of audit victories be reviewed at the Monthly Quality Assurance Meeting and Quarterly Meetings over the duration of the audit process to ensure compliance and reassessed for further action.	o vill and dits en vill		
	room. On 5/21/24 at 10:32 A	AM, the surveyor						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			C <b>05/29/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723		30,20,202	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	spoke with the U.S. and was instructed the required between each cut up and in between confirmed that hand in the day prior in between assisting residents with the day prior in between assisting residents with the day prior in between assisting residents with the day prior in between any interactional transfer of the facility of the person "overset to meal service.  On 5/29/24 at 10:13 Are in the present of the facility last revised January and Cutting up for the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January apersonnel shall follow hygiene procedures to the facility last revised January aperson hygiene procedures to the facility last revised last facility last revised last facility last revise	PN #1 who stated that they FOIA (b) (6) at hand hygiene was the resident when food was a tray pass. UM/LPN #1 hygiene was not performed then each tray pass and after the their meal set up. PM, the surveyor interviewed  Who stated that it was as to perform hand hygiene ction with lunch trays that tent utensils for meal set up. If the hand sanitation of dining room, the price were to be handed out the teing the dining room prior  AM, the U.S. FOIA (b) (6) the of the prevent be passing out tood.  AN the provent the spread of sonnel, residents, and to help prevent the spread of sonnel, residents, and to help prevent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel, residents, and to spread the provent the spread of sonnel	F8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		315453	B. WING			C <b>05/29/2024</b>		
	ROVIDER OR SUPPLIER	(		STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723		03/23/2024		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PLAN OF CORRECTION TIVE ACTION SHOULD BE SED TO THE APPROPRIATE (FICIENCY)	(X5) COMPLETION DATE		
F 880	Continued From page	e 56	F	380				
	2. On 5/22/24 at 7:45 Resident #16 in bed.	AM, the surveyor observed						
	The surveyor reviewe Resident #16.	ed the medical record of						
	admission summary) was admitted to the faincluded NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)	reflected that the resident acility with diagnoses that (A.4(b)(1) NJ Ex Order 26.4(b)(1) ), order 26.4(b)(1) ) and						
	NJ Ex Order 26.4(b)(1) (NJ Ex NJ Ex Or and (NJ Ex Order 26.4(b)(1)	Order 26.4(b)(1) der 26.4(b)(1)						
	Minimum Data Set (Mated Nuexorder 2824), reflect an and Nuexorder 28.4(1) A furthe	recent comprehensive MDS), an assessment tool red the resident had NUEX ORDER 26.4(b)(1) review revealed the Order 26.4(b)(1) and NUEX C						
	Treatment Administra a physician's order da NJ Ex Order 26.4(b)(1) with apply NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) ), w (NJ Ex Order 26.4 daily and wher	ch was transcribed onto the ation Record (TAR) included ated NJ Ex Order 26.4(b)(1),  (NJ Ex Order 26.4(b)(1)) and (NJ Ex Order 26.4						
	cover with daily and prn; NJ Ex C	and with NJ Ex Order 26.4(b)(1)						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315453 R WING 05/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **75 OLD TOMS RIVER ROAD** COMPLETE CARE AT SHORROCK **BRICK, NJ 08723** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 57 F 880 F 880 J Ex Order 26.4(b)(1) for 3-5 minutes, apply and NJ Ex Order 26.4(b)(1), cover with daily and prn. On 5/22/24 at 10:55 AM, the surveyor observed LPN #2 perform a treatment to Resident #16's with UM/LPN #2 who assisted with the The surveyor observed the resident's following: LPN #2 disinfected the over-bed table (OBT) with sanitizing wipes and applied a clean barrier. LPN #2 then assembled the needed supplies from the treatment cart and placed them on the OBT in the resident's room. Among the supplies were a bottle of NJ Ex Order 26.4(b)(1), a tube of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1 , scissors, and a marker. The LPN put small amounts of the NJ Ex Order 26.4(b)(1) into two separate medicine cups. LPN #2 provided the treatment for Resident #16's according to the physician's orders, and after the treatment, the LPN put the scissors she used to remove the NJ Ex Order 26.4(b)(1) and the pen she used to initial and date the into her pocket without first sanitizing them. The LPN then placed the tube of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) back into the treatment cart without sanitizing them. The LPN did not sanitize the overbed table after she completed the treatment. On 5/22/24 at 11:49 AM, the surveyor interviewed LPN #2 regarding the treatment observation who acknowledged that she should not have brought the tube of NJ Ex Order 26.4(b)(1) and bottle of NJ Ex Order 26.4(b)(1) into the resident's room;

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315453	B. WING			l	29/2024	
	ROVIDER OR SUPPLIER			75	REET ADDRESS, CITY, STATE, ZIP CODE OLD TOMS RIVER ROAD RICK, NJ 08723	1 03/	23/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880	She further confirme put the contaminated her pocket but rather and then returned the On 5/24/24, at 11:47 interviewed the used in a resident's before being placed  On 5/24/24 at 12:06 the U.S. FOIA (b) (6) who contained the last of t	en only what she needed. d that she should not have d scissors and marker into r should have sanitized them em to the treatment cart.  AM, the surveyor who confirmed that anything room should be disinfected in the treatment cart.  PM, the surveyor interviewed onfirmed that LPN #2 should tube of the room, but only the the treatment. The US FOIA(D) (6) the scissors and marker should and and returned to the  ty's "Clinical Competency ressing-Aseptic" checklist materials and PPE according olicy.  32 AM, the surveyor the in bed and observed CNA re. The surveyor observed d Resident #8's US OF OFF TO SERVED ands with water, applied ely placed her hands under	F	380				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	IPLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		315453	B. WING _			C <b>05/29/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	I	03/23/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	the US. FOIA Who confirm their hands with soap stream of water.  On 5/24/24 at 12:06 Fthe US. FOIA (6) (6), who coapply soap to their has seconds before placin water.  A review of the facility last revised January 2 personnel shall follow hygiene procedures to infection to other personal visitors7. Use an also containing at least 62 soap (antimicrobial or water for the following after eating or handling assisting a resident vigorously lather hand	PM, the surveyor interviewed infirmed that staff should indicate and lather for 30 mg them under running included 2. All included 2. All included 2. All included 3. All included 4. All included 5. All included 5. All included 6. All inclu	F8			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		656003	B. WING		05/2	9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
COMPLE	TE CARE AT SHORROCK	75 OLD TO	OMS RIVER RO	OAD		
		BRICK, N.	08723			T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
S 560	8:39, standards for lic Facilities. The facility Correction, including deficieny and ensure implemented. Failure result in enforcement the provisions of the I Code, Title 8, chapter licensure regulations.	Jersey Administrative code, censure of Long Term Care must submit a Plan of a completion date for each that the plan is to correct deficiencies may action in accordance with New Jersey Administrative 43E, enforcement of	S 560			7/19/24
	Federal, State, and lo regulations.  This REQUIREMENT by:	is not met as evidenced				
	documents, it was de maintain the required staff-to-resident ratios of New Jersey for 63 63 overnight shifts re	nd review of pertinent facility termined the facility failed to minimum direct care s as mandated by the state out of 63 day shifts and 3 of		Residents affected by deficient practic The facility failed to maintain the requiminimum direct cares staff-to-resident rations as mandated by the State of N Jersey.  Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected.  What corrective action will be accomplished for those residents affected.	ired t lew e	
		ey Department of Health		by the deficient practice:  All residents were monitored for any		

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

TITLE (X6) DATE

**Electronically Signed** 

06/10/24

	or prejoirnoire		(V2) MULTIPLE	E CONSTRUCTION	(X3) DATE S	LIDVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLE	
			A. BUILDING:			
						;
		656003	B. WING		05/2	9/2024
NAME OF B		OTDEET ADS	DEGG OFF OF	ATE ZID CODE		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, ST			
COMPLET	E CARE AT SHORROCK		OMS RIVER RO	DAD		
		BRICK, NJ	08723			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIE	D/ME
			+		-	
S 560	Continued From page	e 1	S 560			
	with N.J.S.A. (New Je	ersey Statutes Annotated)		adverse effects with none noted.		
		um staffing requirements for		Director of Nursing, Human Resource	es .	
	nursing homes," indic	- · · · · · · · · · · · · · · · · · · ·		Director, and Staffing, Coordinator we		
	Governor signed into			re-educated on the minimum staffing		
		0:13-18 (the Act), which		requirements on 6/4/2024 by the		
		staffing requirements in		Administrator.		
	nursing homes. The f			The facility has implemented a compe	atitive	
	effective on 02/01/20	• ,		market rate for nurses and certified	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	CHCOUVE OH OZ/O I/ZO	£ 1.		nursing aides. The facility continues to	_	
	One Certified Nurse A	Aide (CNA) to every eight		utilize online recruitment with immedia		
	residents for the day			interviews and contingency offers.	110	
	residents for the day .	Siliit.		The facility implemented an expediate	-d	
	One direct care staff i	member to every 10		but robust onboarding process.	,u	
		ning shift, provided that no		The facility will use agency staff as ne	odod	
		staff members shall be		to meet staffing needs.	eueu	
		ct staff member shall be		Facility will continue to participate in a	,	
		a CNA and shall perform		bi-weekly recruitment call to review or		
	nurse aide duties: and			positions, recruitment tactics, and	Jeli	
	nuise alue uulles. and	u		changes to improve outcomes. All the	000	
	One direct care staff i	mombor to overy 14		efforts will provide an opportunity to m		
		t shift, provided that each		the required staffing minimums.	ieei	
		ber shall sign in to work as a		the required stanning minimums.		
				Magaziros er avetemie changes to ens	nuro	
	CNA and perform CN	A duties.		Measures or systemic changes to ens	Jule	
	During entrance confe	erence on 5/20/24 at 9:54		that the deficiencies will not recur:  Administrator/Designee will conduct 2	,	
	•			, 9		
		ed the Licensed Nursing		audits weekly for 4 weeks, then twice		
	,	LNHA) and Director of		monthly for 2 months to ensure adequ	Jale	
		he facility's staff was, and		staff is scheduled to accommodate		
		staffing was good; that the		resident needs.	-4	
	-	y Staff as needed. At that		Results of the audits will be reviewed		
		quested the Nurse Staffing		the Monthly Quality Assurance Meetin		
		ed for the following weeks:		and Quarterly over the duration of the		
		1/8/23 to 1/14/23; 5/7/23 to		audit process to ensure compliance a	nd	,
	-	20/23; 8/27/23 to 9/2/23;		reassessment for further action.		,
		18/24 to 2/24/24; 5/5/24 to				,
	5/11/24; and 5/12/24	to 5/18/24.		0500 P-++ P		,
	<b>.</b>	1.0 6 22		S560- Part B		,
		ed the facility completed				,
	Nurse Staffing Report	ts which revealed the		Residents affected by deficient practic		,
	following:			The facility failed to notify the Clearing	ן	

New Jers	ey Department of Heal	th			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		656003	B. WING		C <b>05/29/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE ZIP CODE	,1
TO WILL OF T	NOVIDER OR GOLF EIER		OMS RIVER RO		
COMPLET	E CARE AT SHORROCK	BRICK, NJ			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S 560	Continued From page	2	S 560		
	1. For the week of Co 12/25/22 to 12/31/22, CNA staffing for resid follows:  12/25/22 had 12 CNA day shift, required at 12/26/22 had 11 CNA day shift, required at 12/27/22 had 11 CNA day shift, required at 12/28/22 had 13 CNA day shift, required at 12/29/22 had 13 CNA day shift, required at 12/30/22 had 13 CNA day shift, required at 12/31/22 had 11 CNA day shift, required at 12/31/22 had 11 CNA day shift, required at 12/31/23 had 11 CNA follows:  1/8/23 had 8 CNAs for shift, required at least 1/9/23 had 10 CNAs day shift, required at least 1/10/23 had 10 CNAs day shift, required at 1/11/23 had 13 CNAs day shift, required at 1/13/23 had 13 CNAs	Implaint staffing from the facility was deficient in ents on 7 of 7 day shifts as  as for 132 residents on the least 16 CNAs. Is for 132 residents on the least 16 CNAs. Is for 132 residents on the least 16 CNAs. Is for 132 residents on the least 16 CNAs. Is for 132 residents on the least 16 CNAs. Is for 132 residents on the least 16 CNAs. Is for 132 residents on the least 16 CNAs. Is for 132 residents on the least 16 CNAs. Is for 132 residents on the least 16 CNAs. Is for 132 residents on the least 16 CNAs. Is for 132 residents on the least 16 CNAs. In for 131 residents on the least 16 CNAs. If or 131 residents on the least 16 CNAs. If or 131 residents on the least 16 CNAs. If or 131 residents on the least 16 CNAs. If or 131 residents on the least 16 CNAs. If or 132 residents on the least 16 CNAs. If or 134 residents on the least 16 CNAs. If or 135 residents on the least 16 CNAs. If or 136 residents on the least 16 CNAs. If or 137 residents on the least 16 CNAs. If or 139 residents on the least 16 CNAs. If or 129 residents on the		House Coordinator of a Certified Nurs Aide (CNA) who was services after the aide was discovered resident's room on duty NJ Ex Order 26.4b1 as mandated by the State New Jersey.  Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected.  What corrective action will be accomplished for those residents affe by the deficient practice:  The Clearing House Coordinator was notified on 7/16/2024.  All residents were monitored for any adverse effects with none noted. The facility will immediately report evertermination of any involved staff mem if discovered sleeping on duty, impair or under the influence of a substance mandated by the State of New Jersey the Clearing House Coordinator. The Human Resources Director, Director of Nursing, and Licensed Nursing Hor Administrator were reeducated on 6/4/2024 by the Regional Administrator the requirements of reporting and investigating allegations of neglect and the following facility policies: Abuse, Neglect, Exploitation and Misappropri Prevention Program and Substance A in the Workplace.	eir d of e cted ery ber, ed, , as to ctor me or on d on ation
	1/13/23 had 13 CNAs day shift, required at	for 129 residents on the			

that the deficiencies will not recur:

day shift, required at least 16 CNAs.

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		656003	B. WING		05/2	9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COMPLET	E CARE AT SHORROCK	75 OLD TO	MS RIVER RO	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S 560	Continued From page	· 3	S 560	,		
5 560	3. For the two weeks 5/7/23 to 5/20/23, the staffing for residents of follows:  5/7/23 had 14 CNAs is shift, required at least 5/8/23 had 15 CNAs is shift, required at least 5/9/23 had 16 CNAs is shift, required at least 5/10/23 had 14 CNAs day shift, required at 15/11/23 had 14 CNAs day shift, required at 15/12/23 had 13 CNAs day shift, required at 15/13/23 had 8 CNAs is shift, required at 15/13/23 had 10 CNAs day shift, required at 15/15/23 had 14 CNAs day shift, required at 15/16/23 had 14 CNAs day shift, required at 15/17/23 had 13 CNAs day shift, required at 15/17/23 had 13 CNAs day shift, required at 15/18/23 had 17 CNAs day shift, required at 15/18/23 had 17 CNAs day shift, required at 15/19/23 had 17 CNAs day shift	of Complaint staffing from facility was deficient in CNA on 14 of 14 day shifts as  for 161 residents on the day i 20 CNAs. for 161 residents on the day i 20 CNAs. for 159 residents on the day i 20 CNAs. for 158 residents on the least 10 CNAs. for 154 residents on the least 19 CNAs. for 151 residents on the least 19 CNAs. for 153 residents on the least 19 CNAs. for 151 residents on the least 19 CNAs.	5 500	Human Resources Director/Designee conduct audits of employee files upon termination to ensure that any allegati of neglect are reported and investigate as required and the Clearing House Coordinator is notified as mandated by State of New Jersey. Audits will be completed weekly for 4 weeks, then to monthly for 2 months.  Results of the audits will be reviewed the Monthly Quality Assurance Meetin and Quarterly over the duration of the audit process to ensure compliance at reassessed for further action.	ons ed y the vice at g	
	8/27/23 to 9/2/23, the	omplaint staffing from facility was deficient in CNA on 7 of 7 day shifts as				

New Jersey Department of Health

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
						;
		656003	B. WING	<del></del>	05/2	29/2024
					,	,
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADL	DRESS, CITY, STA	ATE, ZIP CODE		
COMPLET	E CARE AT SHORROCK	75 OLD TO	MS RIVER RO	DAD		
OOMII EEI	L CARL AT CHORROOM	BRICK, NJ	08723			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
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				DEFICIENCY)		
S 560	Continued From page	. 1	S 560			
3 300	Continued From page	÷ 4	3 300			
	8/27/23 had 7 CNAs f	for 144 residents on the day				
	shift, required at least					
	· ·	for 144 residents on the				
	day shift, required at I					
		for 144 residents on the				
	day shift, required at I	least 18 CNAs.				
	8/30/23 had 13 CNAs	for 144 residents on the				
	day shift, required at I	least 18 CNAs.				
	-	for 144 residents on the				
	day shift, required at I					
	• •	for 146 residents on the day				
		•				
	shift, required at least					
		for 146 residents on the day				
	shift, required at least	t 18 CNAs.				
	5. For the week of Co	mplaint staffing from				
	1/21/24 to 1/27/24, th	e facility was deficient in				
	CNA staffing for resid	ents on 7 of 7 day shifts as				
	follows:	,				
	1/21/24 had 11 CNAs	for 147 residents on the				
	day shift, required at I					
	•	for 147 residents on the				
	day shift, required at I					
		for 147 residents on the				
	day shift, required at I					
		for 147 residents on the				
	day shift, required at I	least 18 CNAs.				
		for 147 residents on the				
	day shift, required at I	least 18 CNAs.				
		for 149 residents on the				
	day shift, required at l					
		s for 149 residents on the				
	day shift, required at l	ieast 19 UNAs.				
	6. For the week of Co	· ·				
		e facility was deficient in				
	CNA staffing for resid	ents on 7 of 7 day shifts and				

deficient in total staff for residents on 1 of 7

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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050000		B. WING		1		
		656003	]		<u>  05/2</u>	29/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		75 OLD T	OMS RIVER RO	AD		
COMPLET	E CARE AT SHORROCK	BRICK, N				
	OUR MAR DV OT	<u> </u>		DD0//DD0/ DIAM OF 00DD507101		T
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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				DEFICIENCY)		
C 560	0		S 560			
S 560	Continued From page	5	3 300			
	overnight shifts as fol	lows:				
	2/18/24 had 10 CNAs	for 150 residents on the				
	day shift, required at	least 19 CNAs.				
	2/18/24 had 10 total s	staff for 150 residents on the				
	overnight shift, require	ed at least 11 total staff.				
		for 150 residents on the				
	day shift, required at	least 19 CNAs.				
	2/20/24 had 14 CNAs	for 150 residents on the				
	day shift, required at least 19 CNAs.					
	2/21/24 had 12 CNAs for 150 residents on the					
	day shift, required at least 19 CNAs.					
	2/22/24 had 15 CNAs	for 150 residents on the				
	day shift, required at least 19 CNAs. 2/23/24 had 16 CNAs for 145 residents on the					
	day shift, required at	least 18 CNAs.				
	2/24/24 had 14 CNAs	for 145 residents on the				
	day shift, required at	least 18 CNAs.				
	7. For the two weeks	of staffing prior to survey				
	from 5/5/24 to 5/18/24	1, the facility was deficient in				
		ents on 14 of 14 day shifts				
	and deficient in total s	staff for residents on 2 of 14				
	overnight shifts as fol	lows:				
	5/5/24 had 8 CNAs fo	r 156 residents on the day				
	shift, required at least	t 19 CNAs.				
	5/6/24 had 15 CNAs t	for 155 residents on the day				
	shift, required at least	19 CNAs.				
	5/7/24 had 14 CNAs t	for 155 residents on the day				
	shift, required at least	19 CNAs.				
	5/8/24 had 15 CNAs t	for 155 residents on the day				
	shift, required at least	19 CNAs.				
	5/9/24 had 14 CNAs t	for 155 residents on the day				
	shift, required at least	: 19 CNAs.				
	5/10/24 had 13 CNAs	for 155 residents on the				
	day shift, required at	least 19 CNAs.				[
	5/11/24 had 16 CNAs	for 155 residents on the				[
	day shift, required at	least 19 CNAs.				
		aff for 155 residents on the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '			(X3) DATE SURV COMPLETED		
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		656003	B. WING		05/29/20	024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		, 75 OLD T	OMS RIVER RO	AD			
COMPLE	TE CARE AT SHORROCK	BRICK, N	J 08723				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE C	(X5) OMPLETE DATE	
S 560	Continued From page	e 6	S 560				
	overnight shift, requir	ed at least 11 total staff.					
	day shift, required at 5/13/24 had 15 CNAs day shift, required at 5/14/24 had 14 CNAs day shift, required at 5/15/24 had 15 CNAs day shift, required at 5/16/24 had 14 CNAs day shift, required at 5/17/24 had 13 CNAs day shift, required at 5/18/24 had 16 CNAs day shift, required at 5/18/24 had 8 total st overnight shift, required at 5/18/24 had 8 total st overnight shift, required at 5/18/24 had 8 total st overnight coordina scheduled CNAs bas scheduling one CNA during the day shift; or residents during the for every twelve resid shift. The Staffing Coused Agency Staff for needed, but the some to the facility as schedulity as	s for 159 residents on the least 20 CNAs. s for 159 residents on the least 20 CNAs. s for 159 residents on the least 20 CNAs. s for 159 residents on the least 20 CNAs. s for 159 residents on the least 20 CNAs. s for 159 residents on the least 20 CNAs. s for 159 residents on the least 20 CNAs. saff for 159 residents on the least 20 CNAs. saff for 159 residents on the least 21 total staff.  AM, the surveyor interviewed tor who stated she lead on the census; to every eight residents one CNA for every ten levening shift; and one CNA lents during the overnight coordinator stated that she refuses and CNAs as letimes they did no show up duled. The Staffing ledged the facility did not					
	documents, it was de	nd review of pertinent facility termined that the facility earing House Coordinator of					

New Jers	ey Department of Hea	ıtn				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREETADL	RESS, CITY, STA	ITE, ZIP CODE		
COMPLET	E CARE AT SHORROCK	, 75 OLD TO	MS RIVER RO	AD		
COMPLE	E CARE AT SHORROCK	BRICK, NJ	08723			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N.	(X5)
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			1	DEFICIENCY)		
0.500	- "	_	0.500			
S 560	Continued From page	e 7	S 560			
	NJ Ex Order 26.4b1 of their se	rvices after the aide was				
		n a NJ Ex Order 26.4(b)(1) on duty				
	NJ Ex Order 26.4(b) and N. I Ex Or	der 26.4(b)(1) of a NJ EX Order 26.4(b)(1)				
		State of New Jersey. This				
	deficient practice was					
		files reviewed and the				
	findings were as follo	wed:				
	Reference: New Jers	ey Administrative Code Title				
	13 Law and Public Sa	afety Chapter 45E Health				
		•				
	Care Professional Reporting Responsibility. Subchapter 3:					
	Subchapter 5.					
	12:45E 2.1 Notification to the Clearing House					
	13:45E-3.1 Notification to the Clearing House Coordinator by a Health Care Entity					
	Coordinator by a Hea	iith Care Entity				
		d in (c) below, a health care				
		rt with the Clearing House				
	Coordinator concerni	ng a health care				
	professional who is e	mployed by, under contract				
	to render professiona	l services to, has clinical				
	privileges granted by	that health care entity, or				
		ervices pursuant to an				
		alth care services firm or				
	staffing registry if:					
	otaling region y ii.					
	1) For reasons relatin	a to hoalth care				
		ment, incompetency or				
		uct, which incompetency or				
	•	uct relates adversely to				
	patient care or safety	, the health care entity:				
		orarily revokes or suspends				
	or permanently reduc	es, suspends or revokes the				
		nal's full or partial clinical				
	privileges or practice;					
	ii) Removes the healt	h care professional from the				
	list of eligible employe	ees of health services firm or	1			

New Jers	sey Department of Heal	ith			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		656003	B. WING		C <b>05/29/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
COMPLET	TE CARE AT SHORROCK	75 OLD TO BRICK, NJ	DMS RIVER RO J 08723	AD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
S 560	Continued From page	∍ 8	S 560		
	staffing registry;				
	iii) Discharges the health	alth care professional from care entity; or			
	-	cinds a contract with the nal to render professional			
	AM, the surveyor ask Home Administrator ( Nursing (DON) to pro list of all employees h survey who were still	derence on 5/20/24 at 9:54 at det the Licensed Nursing (LNHA) and Director of evide the survey team with a nired since last standard employed by the facility or requested the facility or Nulex Order 204401			
	from the DON ten em	M, the surveyor requested aployee files including I from the provided list.			
	A review of CNA #1's	files revealed the following:			
	was observed to be NUEX Order 28.4(6)(1)  According	ired on Section 25.40, with an form dated effective summary for "staff U Ex Order 26.4(b)(1) of a g to her, she stated she took corder 26.4(b)(1)] and never			
	blank, and the list of a	oy CNA #1 on Westers of the conditions was left all medications you are notication of use did not			

New Jersey Department of Health							
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		656003	B. WING		05/2	; 9/2024	
NAME OF D	DOMINED ON SURDIVED	CTDEET ADD	DECC CITY CTA	TE ZID CODE			
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA MS RIVER RO	•			
COMPLET	TE CARE AT SHORROCK	BRICK, NJ		AD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
S 560	Continued From page On 5/28/24 at 11:40 A the DON regarding C DON stated she recei US FOJA(b)(b) that aide v NJ EX Order 26.4(b)(1) in a woke CNA #1 up and and went back to wor so she was sen she spoke to CNA #1 she said had been took too much of her DON requested a cop the CNA stated she w but she never of the facility suspected the facility	AM, the surveyor interviewed NA #1's NJEX OTGET 20.4151, and the ived a phone call from the was NJEX OTGET 20.415(1) and she was a NJEX OTGET 20.415(1). Staff I she stated she was rek, but was found NJEX OTGET 26.4(b)(1). Staff I she stated she was rek, but was found NJEX OTGET 26.4(b)(1), and she NJEX OTGET 26.4(b)(1), and she NJEX OTGET 26.4(b)(1). The poy of the NJEX OTGET 20.4(b)(1) and would provide the name with the facility did not not provide the facility did not need to the name of th	S 560				
	A review of the CNA A 3:00 PM to 11:00 PM	Assignment sheet for the shift on shift on the distribution of the shift of the shi					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE S	
		.52, 16, 6,	A. BUILDING: _			
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		656003			05/2	9/2024
NAME OF PE	ROVIDER OR SUPPLIER		RESS, CITY, STA			
COMPLET	E CARE AT SHORROCK	BRICK, NJ	MS RIVER RO 08723	AD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
S 560	Continued From page	<del>2</del> 10	S 560			
	with transferring from with five of the reside assistive device that u	ents who needed assistance bed to chair or chair to bed nts using a state of the control of the				
	On 5/28/24 at 2:05 PM, the DON in the presence of the LNHA, Assistant Director of Nursing (ADON), Regional LNHA, Regional Nurse, and survey team, stated the incident with CNA #1 occurred on stated to the facility the next day to speak with the DON. The DON stated CNA #1 stated she was on an NJ Ex Order 26.4(b)(1) that the aide was unsure of the name, and never provided the The DON could still not speak to who the incident should be reported to.					
	On 5/29/24 at 10:13 AM, the LNHA in the presence of the DON, Regional LNHA, Regional Nurse, and survey team stated the facility would report the incident to the New Jersey Department of Health who would direct the facility to report the incident to anyone further.					
	Workplace" policy dar facility is committed to alcohol-free workplace safety of its residents of alcohol or illegal dr poses a serious healt residentsstaff may residentsstaff may residentsstaff may reaching while impaired on a sonot prohibit appropria and legal prescription treat a disabilitynoth	y's "Substance Abuse in the ted 2020, included the pensuring a drug and the in order to maintain the substance with the safety risk to all the present in the Facility-sanctioned task to the use of over the counter of medication when used to the teuse of over-the-counter the safety risk to all the present in the safety risk to all the present in the safety risk to all the present in the policy does the use of over-the counter the policy is meant to the use of over-the-counter the present in the policy is meant to the use of over-the-counter the present in the policy is meant to the present in the policy is meant to the use of over-the-counter the present in t				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:		(3) DATE SURVEY COMPLETED	
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		656003	B. WING		05/29/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
COMPLET	E CARE AT SHORROCK	75 OLD TO BRICK, N	OMS RIVER RC J 08723	DAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S 560	prescribed under both the extent that it does job performance or sa violation of this policy action, up to and incluemployment. The policy notify the Clearing Ho A review of the facility Exploitation and Misa Program" dated revier protect residents from exploitation or misappropriation of remisappropriation	nedication that can legally be in federal and state law, to innot impair a staff member's afety or safety of othersa is subject to disciplinary uding termination of licy does not include to buse of the impairment.  It's "Abuse, Neglect, ppropriation Prevention wed January 2024, included in abuse, neglect, propriation of property by not limited to: a. facility estigate all possible eglect, mistreatment, or estident property; investigate tions within the timeframes	S 560		
S1695	This REQUIREMENT by: Based on interview ar documents, it was defailed to have a Regis	ssional nurse shall be on cilities with more than 150	S1695	S1695 Mandatory Access to Care Residents affected by deficient practic The facility failed to have a Registered	

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New Jersey Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		656003	B. WING		05/2	9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
COMPLET	E CARE AT SHORROCK	, 75 OLD TO	MS RIVER RC	DAD		
OOMI LL	L CARE AT CHORROOM	BRICK, NJ	08723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S1695	Continued From page	e 12	S1695			
	by the following:	riewed, and was evidenced erence on 5/20/24 at 9:54		Nurse on duty at all times. This deficie practice was identified for 12 out of 42 shifts reviewed.		
	AM, the surveyor ask Home Administrator ( Nursing (DON) how the the LNHA stated that	ed the Licensed Nursing LNHA) and Director of ne facility's staff was, and staffing was good; that the v staff as needed. At that		Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected.	Э	
	time, the surveyor red	quested the Nurse Staffing ed for the following weeks:		What corrective action will be accomplished for those residents affect by the deficient practice: All residents were monitored for any	cted	
	The surveyor reviewe Nurse Staffing Report following:	d the facility completed ts which revealed the		adverse effects with none noted.  Director of Nursing, Human Resource Director, and Staffing, Coordinator we re-educated on the Registered Nurse		
	no Registered Nurse (7:00 AM to 3:00 PM)	5/24 to 5/11/24, there was (RN) on during the day shift on 5/11/24, and during the to 7:00 AM) on 5/6/24; 11/24.		requirements on 6/4/2024 by the Administrator. The facility has implemented a compe market rate for Registered Nurses. Th facility continues to utilize online recruitment with immediate interviews	e	
	no RN during the day	ne night shift on 5/12/24,		contingency offers. The facility implemented an expediate but robust onboarding process. The facility will use agency staff as ne to meet staffing needs.	ed	
		M, the surveyor requested rsing schedules from 5/5/24		Facility will continue to participate in a bi-weekly recruitment call to review or positions, recruitment tactics, and changes to improve outcomes. All the	se	
		ng schedules provided no RN on duty for the twelve week period reviewed.		efforts will provide an opportunity to me the required staffing minimums.		
	the Staffing Coordina	AM, the surveyor interviewed tor who confirmed that a RN all times in the building. The		Measures or systemic changes to ens that the deficiencies will not recur: Administrator/Designee will conduct 2 audits weekly for 4 weeks, then twice		

monthly for 2 months to ensure adequate

facility had six RNs plus the DON, Assistant

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New Jersey Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	656003		B. WING		C <b>05/29/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE	1 00/23/2024	
COMPLE	TE CARE AT SHORROCK	75 OLD TO BRICK, NJ	MS RIVER RO 08723	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
S1695	Director of Nursing (A Data Set (MDS) Coor reviewed the past two Staffing Coordinator word always have a RN On 5/28/24 at 1:57 PI LNHA, DON, ADON, Regional Nurse about No additional information A review of the facility September 2023, including sufficient numbers of competency necessal services for all reside resident care and facinurses and certified in available 24 hours a control of the past of the facility september 2023, including the fac	ADON), and the Minimum dinator. The surveyor of weeks of staffing with the who confirmed the facility did in the building.  M, the surveyor informed the Regional LNHA, and it the above findings.  The surveyor informed the Regional LNHA and it with the surveyor informed the Regional LNHA and it with the surveyor informed the Regional LNHA and it will be above findings.  The surveyor informed the Regional LNHA and it was provided.  The surveyor informed the Regional LNHA and it was provided.  The surveyor informed the Regional LNHA and it was provided and in accordance with in a	S1695	Registered Nurses are on the schedu accommodate resident needs as required Results of the audits will be reviewed the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance a reassessment for further action.	ired. at g	

#### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
315453 <sub>Y1</sub>	B. Wing	Y2	8/7/2024	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLETE CARE AT SHORROC	K	75 OLD TOMS RIVER ROAD		
		BRICK, NJ 08723		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0609		Correction	ID Prefix	F0610		Correction	ID Prefix	F0677		Correction
Reg. #	483.12(b)(5)(i)(A) (1)(4)	(B)(c)	Completed	Reg. #	483.12(	c)(2)-(4)	Completed	Reg.#	483.24(a)(2)		Completed
LSC			07/19/2024	LSC			07/19/2024	LSC			07/10/2024
ID Prefix	F0698		Correction	ID Prefix	F0711		Correction —	ID Prefix	F0712		Correction
Reg.#	483.25(I)		Completed	Reg. #	483.30(	b)(1)-(3)	Completed	Reg.#	483.30(c)(1)-(4)		Completed
LSC			07/10/2024	LSC			07/10/2024	LSC			07/10/2024
ID Prefix	F0725		Correction	ID Prefix	F0812		Correction	ID Prefix	F0814		Correction
ID I ICIIX	483.35(a)(1)(2)		Correction	I I I I I I I I I		i)(1)(2)	—	ID I ICIIX	483.60(i)(4)		Correction
Reg.#	403.33(a)(1)(2)		Completed	Reg. #	483.60(	1)(1)(2)	Completed	Reg. #	403.00(1)(4)		Completed
LSC			07/10/2024	LSC			07/10/2024	LSC			07/10/2024
ID Prefix	F0880		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	483.80(a)(1)(2)(4	)(e)(f)	Completed	Reg. #			Completed	Reg. #			Completed
LSC			07/10/2024	LSC			_	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#			Completed	Reg.#			Completed	Reg.#			Completed
LSC			·	LSC			_ · _	LSC			·
REVIEWEI		REVIEWE (INITIALS		DATE		SIGNATURE OF S	BURVEYOR			DATE	
REVIEWE	D BY	REVIEWE (INITIALS		DATE		TITLE				DATE	
<b>FOLLOW</b> L 5/29/2024	JP TO SURVEY CO	OMPLETED	ON				ED DEFICIENCIES S (CMS-2567) SEN			YES	в 🔲 по

				ST	ATE FORM: RE	VISIT REPORT					
	R / SUPPLIER / CI CATION NUMBER	_IA /	MULTIPLE CONS A. Building	STRUCTION						F REVISIT	
656003		Y1	B. Wing					Y2	8/7/202	4 <sub>Y3</sub>	
	FACILITY TE CARE AT SH	HORROC	К			STREET ADDRESS, CIT 75 OLD TOMS RIVER R BRICK, NJ 08723		DDE			
corrective	This report is completed by a State surveyor to she corrective action was accomplished. Each deficier identification prefix code previously shown on the streport form).				e fully identified usi	ng either the regulation	or LSC provision	n number and	the		
ITEI	И		DATE	ITEM		DATE	ITEM			DATE	
Y4			Y5	Y4		Y5	Y4		Y5		
ID Prefix	S0560		Correction	ID Prefix	S1695	Correction	ID Prefix			Correction	
Reg.#	8:39-5.1(a)		Completed	Reg. #	8:39-25.2(e)	Completed	Reg. #			Completed	
LSC	_		07/19/2024	LSC	-	07/10/2024	LSC _				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg.#			Completed	Reg. #		Completed	Reg. #			Completed	
LSC			_	LSC			LSC				
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LSC			_	LSC			LSC				
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Reg.#			Completed	Reg. #		Completed	Reg. #			Completed	
LSC			_	LSC			LSC _				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix —			Correction	
Reg.#			Completed	Reg. #		Completed	Reg. #			Completed	
LSC			_	LSC			LSC _				
REVIEWE STATE AG		REVIEW (INITIAL		DATE	SIGNATUR	RE OF SURVEYOR	•		DATE		
REVIEWE CMS RO	D BY	REVIEW (INITIAL		DATE	TITLE				DATE		
	FOLLOWUP TO SURVEY COMPLETED ON 5/29/2024				CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						

Page 1 of 1

EVENT ID:

TL3Q12

(11/06)

PRINTED: 11/07/2024 FORM APPROVED OMB NO. 0938-0391

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			05/	29/2024
	ROVIDER OR SUPPLIER			75	TREET ADDRESS, CITY, STATE, ZIP CODE 5 OLD TOMS RIVER ROAD RICK, NJ 08723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
K 000 K 321 SS=D	LLC on behalf of the Health (NJDOH), Health (NJDOH), Health (NJDOH), Health community in substantial community in substan	care Management Solutions, New Jersey Department of alth Facility Survey and Field 24. The facility was found to pliance with 42 CFR 483.73.  urvey was conducted by ent Solutions, LLC on sey Department of Health ility Survey and Field 24 and the facility and was inpliance with the cipation in 42 CFR 483.90(a), Life the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19 EXISTING icy.  orrock Gardens is a instructed in 1998 and ction on 11/11/96. It is (111) construction and has ents. The facility is fully system (with five risers). powers 75% of the building. ied beds was 158 out of	K				7/10/24
	having 1-hour fire res	nclosure protected by a fire barrier istance rating (with 3/4 hour automatic fire extinguishing					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	_		TITLE		(X6) DATE

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.

**Electronically Signed** 

Facility ID: NJ656003

06/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G <b>01</b>	(X3) DATE SURVEY COMPLETED
		315453	B. WING	<del></del>	05/29/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD		
		_		75 OLD TOMS RIVER ROAD	
COMPLE	TE CARE AT SHORROCK			BRICK, NJ 08723	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
K 321	When the approved a system option is used separated from other partitions and doors in Doors shall be self-cland permitted to have protective plates that from the bottom of the Describe the floor and hazardous areas that 19.3.2.1, 19.3.5.9  Area  Separation N/A a. Boiler and Fuel-Fir b. Laundries (larger the compact of the facility in Life Safety Code (20° deficient practice had and any residents in the compact of the compact of the compact of the compact of the facility in Life Safety Code (20° deficient practice had and any residents in the compact of the compact of the compact of the facility in Life Safety Code (20° deficient practice had and any residents in the compact of the compa	e with 8.7.1 or 19.3.5.9. Intomatic fire extinguishing of the areas shall be spaces by smoke resisting in accordance with 8.4. It is in a coordance with 8.4. It is in the potential to affect staff the area. It is in the size of the coordance with 8.4. It is in the potential to affect staff the area.	K 32	K321 Hazardous Areas - Enclosur Residents affected by deficient pra The facility failed to separate hazar areas from other parts of the facility accordance with NFPA 101 Life Sa Code (2012 Edition), Section 8.4.  Identify those individuals who could affected by the deficient practice: This deficient practice had the pote affect all staff and residents in the	ctice: rdous y in fety d be

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	PLE CONSTRUCTION G <b>01</b>	N	(X3) DATE SURVEY COMPLETED
		315453	B. WING _			05/29/2024
	ROVIDER OR SUPPLIER	ζ.	•	STREET ADDRES 75 OLD TOMS R BRICK, NJ 08		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAG	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K 321	separating it from the measured over 70 sq contained stored comboxes).  During an interview a the U.S. FOIA (b) and revealed the facility	as missing from the door Corridor. The room uare feet (sq ft) in size and abustibles (paper, cardboard  t the time of the observation, (6) confirmed the finding lity was unaware a as required on the door.	K	What correaccomplise by the definal staff are any adversible. The self-close separating 200 Hall from 5/22/20 All other refeet and sea audited for hardware. The Region conducted 5/22/2024 NFPA 101 including the self-closin excess of combustible self-closin excess of combustible weeks, the the Mainter rooms in eastoring conself-closin audits will Quality As over the densure confurther act	coms in excess of 50-square toring combustibles were a appropriate self-closing. No issues were found. Onal Director of Maintenance of an in-service training on to the maintenance staff on the Hazardous Area Enclosure the requirement to have aghardware on all rooms in 50-square feet and storing oles.  To respect to the deficiencies will not be conducted weekly for four the monthly for two months by the ence of 50-square feet and mbustibles to ensure they have aghardware. Results of the be reviewed at the Monthly issurance Meeting and Quarte duration of the audit process to mpliance and reassessed for	for ne d n all ve
SS=F		<b>5</b>				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			05/:	29/2024
	ROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE  5 OLD TOMS RIVER ROAD  5RICK, NJ 08723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 331	fixed or movable wallshave a flame spread of The reduction in class sprinkler system as permitted.  10.2, 19.3.3.1, 19.3.3 Indicate flame spread of This REQUIREMENT by:  Based on observation interview, the facility of finishes had a flame of with NFPA 101 Life Strong Code) 2012 Edition, of This deficient practice 74 residents.  Findings include:  An observation on 05 the corridor wall, located the 100 and 200 wing having an unknown of the wall covering was of the wall and stopped covering was loosely longer tightly fitting.  Record review on 05/specifications were precarpet for use in horizero.	ng Finish  ng finishes, including nces of buildings such as s, partitions, columns, and rating of Class A or Class B. s of interior finish for a rescribed in 10.2.8.1 is  2 rating(s).  is not met as evidenced an, record review, and failed to ensure interior wall spread rating in accordance afety Code (Life Safety Section 19.3.3 and 10.2. be had the potential to affect  //21/24 at 10:22 AM revealed ted in the exit hallways of s was covered with carpet ertical flame spread rating. s installed on the bottom half and at the handrails. The wall attached to the wall and no	K	3331	K331 Interior Wall and Ceiling Finish Residents affected by deficient practice. The facility failed to ensure interior wall finishes had a flame spread rating in accordance with NFPA 101 Life Safety Code (Life Safety Code) 2012 Edition, Section 19.3.3 and 10.2.  Identify those individuals who could be affected by the deficient practice: This deficient practice had the potentia affect all staff and residents in that area No residents or staff were affected.  What corrective action will be accomplished for those residents affect by the deficient practice: All staff and residents were monitored from any adverse effects with none noted. The interior wall finishes in the corridor wall, located in the exit hallways of the 100 and 200 wings will be treated with	I to a. ted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER:  A. BUILDII			CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			05/	/29/2024
	ROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 5 OLD TOMS RIVER ROAD 5RICK, NJ 08723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	UST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 331	Documentation of the carpet for use in vertirequested by the survivated by the facility During an interview at the U.S. FOIA (b) confirmed the finding not locate documentar rating for the carpet as	flame spread rating of the cal installations was reyor on 05/21/24 at 10:22, M; however, this was not	K	331	fire retardant coating that has Class A flame spread rating for vertical flame resistance that is tested and certified to NFPA 101 Life Safety Code 2012 Editionstandards.  The Maintenance Department was educated by LNHA on NFPA 101 Life Safety Code, Section 19.3.3 and 10.2. including the requirement to ensure that affixed interior wall surfaces have flame spread rating.  Measures or systematic changes to ensure that the deficiencies will not reoccur:  The Maintenance Director/designee will perform inspections of all corridors to ensure that affixed interior wall surfaces have proper flame spread rating once a weekly for 4 weeks then monthly for 2 months. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over duration of the audit process to ensure compliance and reassessed for further action.	on I S	
K 353 SS=F	CFR(s): NFPA 101  Sprinkler System - Management Automatic sprinkler and inspected, tested, and with NFPA 25, Standar Testing, and Maintain Protection Systems. If maintenance, inspect	ing of Water-based Fire Records of system design,	K	353	action.		7/10/24

PRINTED: 11/07/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION 1	(X3) DATE SURVEY COMPLETED	
		315453	B. WING			05/	29/2024
	ROVIDER OR SUPPLIER	<		7	TREET ADDRESS, CITY, STATE, ZIP CODE 5 OLD TOMS RIVER ROAD BRICK, NJ 08723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		<u> </u>			(X5) COMPLETION DATE
K 353	Continued From pag a) Date sprinkler sy b) Who provided sy c) Water system su Provide in REMARK: any non-required or system. 9.7.5, 9.7.7, 9.7.8, and This REQUIREMENT by: Based on observation interview, the facility sprinkler system in a Standard for the Insp. Maintenance of Water Systems (2011 Edition had the potential to a resided at the facility Findings include:  A review of the facility system inspections of the facility revealed redry sprinkler system inspections of the facility system inspections of the facility revealed redry sprinkler system inspections of the facility system in system	e 5 stem last checked stem test  pply source  S information on coverage for partial automatic sprinkler  and NFPA 25 T is not met as evidenced  on, record review, and failed to maintain the coordance with NFPA 25 pection, Testing, and er-Based Fire Protection  on). This deficient practice affect all 158 residents who  y's untitled weekly sprinkler locumentation provided by the documented evidence the segueges were inspected. Additionally, there was no be inspections were seeks in November 2023 or		353	K353 Sprinkler System Maintenance at Testing  Residents affected by deficient practice. The facility failed to maintain the sprink system in accordance with NFPA 25 Standard for the Inspection, Testing, an Maintenance of Water-Based Fire Protection Systems (2011 Edition).  Identify those individuals who could be affected by the deficient practice: This deficient practice had the potentia affect all residents who resided at the facility. No residents were affected.  What corrective action will be accomplished for those residents affect by the deficient practice: All residents were monitored for any	and e: .ler nd	
	U.S. FOIA (b) (6) stated the facility was documented evidence inspections of the sp survey. The U.S. For the	on 05/21/24 at 2:00 PM, the confirmed the findings and sunable to provide the of the missing weekly rinkler gauges during the OIA (b) (6) also stated the ware systems and no longer			adverse effects with none noted. The Buildings dry sprinkler systems gauges identified were inspected on 5/22/2024. No issues were found. A facility wide audit for all other dry sprinkler systems gauges was complet by the maintenance staff on 5/22/2024		

Facility ID: NJ656003

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>			(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			05/	29/2024
	ROVIDER OR SUPPLIER  E CARE AT SHORROCK			STREET ADDRESS, CITY, 75 OLD TOMS RIVER RC BRICK, NJ 08723	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 353 K 372 SS=F	Continued From page had access to the doc NJAC 8:39-31.1(c), 3 NFPA 13, 25  Subdivision of Buildin CFR(s): NFPA 101	cumentation.	K 3	ensure their integround.  The Regional Dirconducted an in-5/22/2024 to the maintaining the sworking order an weekly inspection.  Measures or systemsure that the dreoccur:  An audit will be comaintenance director weeks, then to ensure the sprworking order an are documented the audits will be Quality Assurance over the duration ensure compliant further action.	grity. No issues were rector of Maintenance service training on maintenance staff on sprinkler system in good documenting the ns for the identified are tematic changes to reficiencies will not conducted the ector/designee weekly monthly for two month inkler system is in good the weekly inspection as required. Results or reviewed at the Monthe Meeting and Quarter of the audit process to ce and reassessed for	for ns od ns f nly rly	7/10/24
	Construction 2012 EXISTING Smoke barriers shall fire resistance rating permitted to termine Smoke dampers are repenetrations in fully dan approved sprinkler	g Spaces - Smoke Barrier be constructed to a 1/2-hour per 8.5. Smoke barriers shall nate at an atrium wall. not required in duct ucted HVAC systems where r system is installed for adjacent to the smoke					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G <b>01</b>	(X3) DATE SURVEY COMPLETED			
		315453	B. WING	<del> </del>	05/29/2024			
	ROVIDER OR SUPPLIER	ζ.		STREET ADDRESS, CITY, STATE, ZIP CODE  75 OLD TOMS RIVER ROAD  BRICK, NJ 08723				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION			
K 372	in REMARKS.	e 7 nical smoke control system	K 37	72				
	by: Based on observation failed to ensure penewere protected by a sof restricting the transbarriers were continu NFPA 101 Life Safety Sections 8.5.6.1 and practice had the pote Findings include:  An observation on 05 smoke barrier located around a wire penetral and ceiling.  An observation on 05 smoke barrier located around a wire penetral and ceiling.	ns and interviews, the facility trations in smoke barriers system or material capable sfer of smoke and smoke ous in accordance with a Code (2012 Edition) 8.5.6. 2. This deficient initial to affect 158 residents.  2/21/24 at 9:47 AM of the dring in the Corridor by the ed an unsealed two-inch gap ation above the smoke doors  2/21/24 at 9:56 AM of the dring in the Corridor by Room inch unsealed overcut around		K372 Subdivision of building spaces Smoke barrier  Residents affected by deficient praction. The facility failed to ensure penetration smoke barriers were protected by a system or material capable of restrict the transfer of smoke and smoke bar were continuous in accordance with 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2.  Identify those individuals who could be affected by the deficient practice: This deficient practice had the potent affect all residents who reside at the facility.  What corrective action will be accomplished for those residents affects the deficient practice:	ce: ons in ing riers NFPA  oe ial to			
	ceiling.  An observation on 05 smoke barrier located Nurses' Station at the unit revealed a five-in the wall above the closmoke doors.  An observation on 05 smoke barrier located Occupational Therapy overcut around a gro	n observation on 05/21/24 at 10:03 AM of the noke barrier located in the Corridor by the urses' Station at the Evergreen and Meadows it revealed a five-inch square unsealed hole in wall above the clock and ceiling tile, left of the		by the deficient practice: All residents were monitored for any adverse effects with none noted. The unsealed two-inch gap around a penetration above the smoke doors a ceiling of the smoke barrier located in Corridor by the Therapy room was repaired and closed on 5/22/2024. The two-inch unsealed overcut arour wire penetration above the smoke barrilocated in the Corridor by Room 310 repaired and closed on 5/22/2024. The five-inch square unsealed hole in wall above the clock and ceiling tile, I	and in the and a pors ier was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G <b>01</b>	(X3) DATE SURVEY COMPLETED
		315453 B. WING		05/29/2024	
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT SHORROCK				STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723	,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
K 372	An observation on 05 smoke barrier located Closet across from Reeight-inch square gap ceiling as observed from An observation on 05 smoke barrier by Rocovercut around a wire smoke doors and ceil During an interview a observations, the U.S confirmed the findings	/21/24 at 10:34 AM of the linside the Clean Utility from 241 revealed an of in the wall above the hard form above the access panel.  /21/24 at 11:00 AM of the first multiple in 116 revealed a two-inches penetration above the ing tile.  It the time of the S. FOIA (b) (6) and stated the facility was alled gaps and penetrations	К3	the smoke doors related to the barrier located in the Corridor b Nurses' Station at the Evergree Meadows unit was repaired and 5/22/2024.  The three-inch overcut around a wire penetrations related to the and ceiling tile smoke barrier lot the Corridor of the Occupationa was repaired and closed on 5/2 The eight- inch square gap in the above the hard ceiling as obser above the access panel related smoke barrier located inside the Utility Closet across from Room repaired and closed on 5/22/20. The two-inch overcut around a penetration above the smoke Room 116 was repaired and closed on 5/22/2024. A facility wide audit was comple Maintenance Director on 5/22/2 ensure penetrations in smoke be were protected by a system or capable of restricting the transfers smoke and smoke barriers were continuous in accordance with I Life Safety Code (2012 Edition) 8.5.6.1 and 8.5.6.2. No issues found.  The Regional Director of Maintenance is maintaining smoke barriers to exprotection by a system or mater of restricting the transfer of smoke barriers in accordance with a protection by a system or mater of restricting the transfer of smoke barriers in accordance with a protection by a system or mater of restricting the transfer of smoke barriers in accordance with a protection by a system or mater of restricting the transfer of smoke barriers in accordance with a protection by a system or mater of restricting the transfer of smoke barriers in accordance with a protection by a system or mater of restricting the transfer of smoke barriers in accordance with a protection by a system or mater of restricting the transfer of smoke barriers in accordance with a protection by a system or mater of restricting the transfer of smoke barriers in accordance with a protection by a system or mater of restricting the transfer of smoke barriers in accordance with a protection by a system or mater of restricting the transfer of smoke barriers in accordance with a protection by a system or mater of restricting the transfer of smoke barriers in accord	y the n and d closed on a group of billboard cated in I Therapy 2/2024. He wall eved from to the e Clean a 241 was 24. Wire cors and barrier by used on atted by the 024 to carriers material er of e NFPA 101 Sections were enance g on staff on insure cial capable oke and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			05	/29/2024	
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT SHORROCK				STREET ADDRESS, CITY, STATE, ZIP CODE 75 OLD TOMS RIVER ROAD BRICK, NJ 08723				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG				(X5) COMPLETION DATE	
K 923 SS=F	Gas Equipment - Cyli CFR(s): NFPA 101  Gas Equipment - Cyli Greater than or equal Storage locations are ventilated in accordar 5.1.3.3.3.  >300 but <3,000 cubic Storage locations are within an enclosed into limited combustible of gates outdoors) that of gases are not stored separated from comb sprinklered) or enclose noncombustible considerations.	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and		923	Measures or systematic changes to ensure that the deficiencies will not reoccur:  An audit will be conducted by the maintenance director/designee weekly four weeks, then monthly for 2 months ensure the ensure penetrations in smotharriers were protected by a system or material capable of restricting the trans of smoke and smoke barriers were continuous in accordance with the requirement. Results of the audits will be the reviewed at the Monthly Quality. Assurance Meeting and Quarterly over duration of the audit process to ensure compliance and reassessed for further action.	to ke sfer be	7/10/24	

PRINTED: 11/07/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>		(X3) DATE SURVEY COMPLETED	
		315453	B. WING			05/29/2024	
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT SHORROCK				75	TREET ADDRESS, CITY, STATE, ZIP CODE 5 OLD TOMS RIVER ROAD RICK, NJ 08723		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 923	care areas with an acor equal to 300 cubic stored in an enclosur handled with precaut A precautionary sign each door or gate of where the sign include minimum "CAUTION STORED WITHIN NO Storage is planned sof which they are recempty cylinders are scylinders. When faci integral pressure gauconsidered empty is are marked to avoid in the open are prote 11.3.1, 11.3.2, 11.3.3 This REQUIREMENT by:  Based on observation failed to ensure oxygaccordance with NFF Code (2012 Edition), practice had the pote residents.  Findings include:  An observation on 05 revealed one oxyge accordance with NFF Code (2012 Edition), practice had the pote residents.	r immediate use in patient ggregate volume of less than a feet are not required to be se. Cylinders must be sions as specified in 11.6.2. readable from 5 feet is on a cylinder storage room, les the wording as a : OXIDIZING GAS(ES) O SMOKING."  To cylinders are used in order eived from the supplier. segregated from full lity employs cylinders with uge, a threshold pressure established. Empty cylinders confusion. Cylinders stored	K	923	K 923 Gas equipment Cylinder and container storage  Residents affected by deficient practice. The facility failed to ensure oxygen cylinders were secured in accordance NFPA 99 Health Care facilities Code (2012 Edition), Chapter 11.  Identify those individuals who could be affected by the deficient practice: This deficient practice had the potentia affect all staff and residents who reside the facility.  What corrective action will be accomplished for those residents affect by the deficient practice:	actice: on ance with ode ald be tential to	

Facility ID: NJ656003

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		315453	B. WING _			05/29/2024		
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT SHORROCK				STREET ADDRESS, CITY, STATE, ZIP CODE  75 OLD TOMS RIVER ROAD  BRICK, NJ 08723				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROL DEFICIENCY)		BE COMPLETION		
K 923	Continued From page NJAC 8:39-31.2(e) NFPA 99	: 11	KS	923	All residents and staff were monitored any adverse effects with none noted. The one oxygen E cylinder that was no secured and protected from tipping and rupture in was immediately placed in a base and was completely secured and protected.  A facility wide audit was completed by Maintenance Director on 5/22/2024 to ensure oxygen cylinders were secured and protected from tipping and rupture accordance with the regulation. No issuere found.  The Regional Director of Maintenance conducted an in-service training on 5/22/2024 to all facility staff on maintaining all oxygen E cylinders in all areas secured and protected as required. Measures or systematic changes to ensure that the deficiencies will not reoccur:  An audit will be conducted by the maintenance director/designee weekly four weeks, then monthly for 2 months ensure that all oxygen E cylinders in all areas are secured and protected as required. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over duration of the audit process to ensure compliance and reassessed for further action.	the in ues		

#### POST-CERTIFICATION REVISIT REPORT

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PROVIDE IDENTIFIC					K GARDENS					F REVISIT
315453 <sub>Y1</sub> B. Wing									4 <sub>Y3</sub>	
NAME OF FACILITY					STREET ADDRESS, CITY, STATE, ZIP CODE					
COMPLE	TE CAR	E AT S	HORROCK			75 OLD TOMS RIVER F	ROAD			
						BRICK, NJ 08723				
program,	to show and the number	those of date su and the	by a qualified State surveyor deficiencies previously report and corrective action was a de identification prefix code p	orted on the ccomplished	CMS-2567, Stater d. Each deficiency	nent of Deficiencies an should be fully identifi	d Plan of Cor ed using eithe	rection, that have er the regulation o	r LSC	
ITE	М		DATE	ITEM		DATE ITEM				DATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 10	1	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0321		07/10/2024	LSC	K0331	07/26/2024	LSC	K0353		07/10/2024
ID Prefix	NFPA 10	1	Correction	ID Prefix	NFPA 101	Correction	ID Prefix			Correction
Reg.#		1	Completed	Reg. #		Completed	Reg.#			Completed
LSC	K0372		07/10/2024	LSC	K0923	07/10/2024	LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Dog #			Completed	Dog #		Completed	Dog #			Completed
Reg. #			Completed	Reg. #		Completed	Reg. #			Completed
LSC	-			LSC			LSC			
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ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. # Completed		Reg. #		Completed	Reg. #			Completed		
LSC				LSC			LSC			
REVIEWE STATE AG			REVIEWED BY (INITIALS)	DATE	SIGNATUI	RE OF SURVEYOR	<u> </u>		DATE	
REVIEWE CMS RO	D BY		REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 5/29/2024					RRECTED DEFICIENCIE ENCIES (CMS-2567) SEN			□ ve	s 🗆 NO	