STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00166610, NJ00166192, NJ00165057, NJ 00162720, NJ00160299, NJ00159100, NJ00159893, NJ00157098 Survey Date: 10/19/2023 Census: 121 Sample Size: 24 and 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		11/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/02/2023

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.

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F 657	Continued From page 1 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to update and revise a Care Plan in a timely manner to include a Ex.Order 26.4(b)(1) for 1 of 3 residents, (Resident #91), reviewed for Ex.Order 26 This deficient practice was evidenced by the following: On 10/4/23 at 1:04 PM, the surveyor observed Resident #91 sitting upright in a recliner across from the nursing station. The resident's eyes were closed, and he/she did not respond to the surveyor. The surveyor reviewed the medical record for Resident #91. Review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to Ex Order 26. 4B1 [redacted]. Review of a significant change Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated Ex.Order 26.4(b)(1), revealed	F 657	The care plan for resident #91 was reviewed and updated related to Ex Order 26. 4B1 on 8/8/23. All the residents may be affected by this incident. The Regional Clinical Nurse will in-service the nurses, MDS Coordinator, Unit Managers, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Shift Supervisor on requirement to update the residents care plan post incident, with updated interventions. The MDS Coordinator will audit 3 the care plan of 5 residents scheduled for the required assessment for 4 weeks then monthly for 3 months. The MDS Coordinator will submit the audit report to the administrator Quality Assurance Improvement Committee which meets every 3 months	

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F 657	Continued From page 2 that the resident had a Ex Order 26. 4B1 score of [redacted] out of 15, indicating the resident had a Ex Order 26. 4B1 . Review of the electronic progress notes (ePN) dated Ex.Order 26.4(b)(1) at 16:01 (4:01 PM) completed by Licensed Practical Nurse (LPN), included that the resident had an Ex Order 26. 4B1 in the day room. Then LPN documented that the resident had no Ex.Order 26.4(b)(1) . Documentation included that the resident was assisted back into the wheelchair and was placed in front of the nursing station for monitoring. Review of a Ex.Order investigation dated Ex.Order 26.4(b)(1) at 13:30 (1:30 PM), provided by the Licensed Nursing Home Administrator (LNHA) included that the Interdisciplinary Team (IDT) met and reviewed/discussed the incident. It also included that the care plan was revised to include offering the resident assistance back to bed after lunch. This was authored by the Director of Nursing (DON). Review of a Ex.Order investigation dated Ex.Order 26.4(b)(1) included the resident's care plan which did not reflect the Ex.Order 26.4(b)(1) intervention to offer the resident assistance back to bed after lunch. Review of the resident's care plan which was provided to the surveyor on 10/19/23 at 8:30 AM by Regional Registered Nurse (RRN#1), included a revised intervention dated Ex.Order 26.4(b)(1) , to offer resident assistance back to bed after lunch. Review of the history version for care plan interventions included the above noted revised intervention which was authored by the DON on Ex.Order 26.4(b)(1) .	F 657		

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F 657	Continued From page 3 On 10/17/23 at 9:25 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM) who stated that falls were discussed in the morning meetings which included all the department heads and that new interventions were discussed and determined by the team to keep the resident safe. He further stated that new interventions were communicated verbally to the direct care staff as well as added to the resident's care plan. LPN #2 stated "we update care plans almost immediately." On 10/17/23 at 9:42 AM, the surveyor reviewed the care plan in the electronic medical record (EMR) with the LPN/UM. He acknowledged but could not speak to why the [redacted], intervention to offer to assist the resident back to bed after lunch was not added to the care plan until [redacted]. The LPN/UM further stated he would look into "this" and get back to the surveyor with additional information. On 10/17/23 at 11:17 AM, the LPN/UM acknowledged that he still could not speak to why the [redacted] intervention to offer to assist the resident back to bed after lunch was not added to the care plan until [redacted] On 10/19/23 at 10:21 AM, the surveyor interviewed the DON in the presence of the survey team and reviewed the history version for care plan interventions in the EMR. The DON acknowledged that the [redacted] intervention to offer the resident assistance back to bed after lunch was not added to the care plan until [redacted] Review of the facility policy "Falls and Fall Risk	F 657		

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F 657	Continued From page 4 Managing" updated 10/2019, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." Review of the facility policy "Care Plans, Comprehensive Person-Centered" updated 10/2023, included that the comprehensive, person-centered care plan will describe the services that that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being. It also included that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The IDT must review and update the care plan when there has been a significant change in the residents' condition and when the desired outcome is not met. NJAC 8:39-11.2(2)(h)(i), 27.1(a)(b)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint # NJ000162720 Based on interview and review of medical records, it was determined that the facility failed	F 658	Resident #372 was discharged on [redacted]. All the residents may be affected by this practice.	11/17/23

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F 658	Continued From page 5 to to follow professional standards of clinical practice with respect to a.) clarifing a Physician's Order (PO) for *Ex Order 26. 4B1* on admission, b.) accurately transcribe a PO for *Ex Order 26. 4B1* % onto the *Ex Order 26. 4B1* electronic treatment administration (eTAR) and c.) document a *Ex Order 26. 4B1* order as administered on Ex.Order 26.4(b)(1). This deficient practice was identified for 1 of 8 residents (Resident # 372) reviewed for closed records. This deficient practice was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a	F 658	The Regional Clinical Nurse will in-service the nurses, MDS Coordinator, Unit Managers, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Shift Supervisor on following MD orders, properly transcribing orders and completing MD orders The Unit Manager and/or shift supervisor will reconcile the orders of the new admissions. The MDS Coordinator will audit 3 residents care plan of of the scheduled for the required assessment for 4 weeks then monthly for 6 months. The MDS Coordinator will submit the audit report to the administrator Quality Assurance Improvement Committee which meets every 3 months	

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F 658	Continued From page 6 registered nurse or licensed or otherwise legally authorized physician or dentist." On 10/16/23 at 9:48 AM, the surveyor reviewed the closed medical record for Resident # 372. Review of the Face Sheet (an admission record) revealed Resident # 372 was admitted to the facility on Ex Order 26. 4B1 with diagnosis which included but not limited to *Ex Order 26. 4B1* [redacted].	F 658		
	Review of the Admission Progress Notes (PN) dated Ex.Order 26.4(b)(1) timed at 10:04 PM and documented by a Registered Nurse (RN) indicated '*Ex Order 26. 4B1* with opening that is now treated with *Ex Order 26. 4B1* and covered with a Ex Order [redacted] every 6 hours." Review of an untitled document that had typed and handwritten notes dated Ex.Order 26.4(b)(1), revealed a handwritten note "from home Ex.Order 26.4 Ex Order 26. 4B1 [redacted] still Ex Order 26. 4B1 6 h [every six hours] - *Ex Order 26. 4B1* [redacted]." Review of the physician's orders (PO) revealed a PO dated Ex.Order 26.4(b)(1) for '*Ex Order 26. 4B1* [redacted]. Cleanse *Ex Order 26. 4B1* opening with *Ex Order 26. 4B1* and cover with *Ex Order 26. 4B1* every day at 7:00 am - 7:00 pm."			

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F 658	Continued From page 7 Further review of the PO's revealed a PO dated Ex.Order 26.4(b)(1 for 'Ex Order 26. 4B1 apply by Ex Order 26. 4B1 once daily to Ex Order 26. 4B1 after cleansing with Ex Order 26. 4B1 . Cover with clean dressing every day at 7:00 PM - 7:00 am." Review of the January 2023 electronic treatment administration record (eTAR) revealed a PO dated Ex.Order 26.4(b)(1 for Ex Order 26. 4B1 cleanse left groin opening with Ex Order 26. 4B1 and cover with Ex Order 26. 4B1. There was no documented evidence that the Ex Order 26. 4B1 was administered, and the Ex Order 26. 4B1 order did not correlate with the above admission progress note to treat the Ex Order 26. 4B1 with Ex Order 26. 4B1 and cover with a dry dressing every six (6) hours. Further review of the January 2023 eTAR revealed the above corresponding Ex Order 26. 4B1 order plotted for 7:00 pm - 7:00 am. There were dashes in the plotted times on 1/30/23 and 1/31/23. There was no documented evidence that the Ex Order 26. 4B1 was administered on Ex.Order 26.4(b)(1) to the Ex Orde . Further review of the medical record revealed a Progress Note dated Ex.Order 26.4(b)(1, and timed at 4:59 pm. The PN indicated an assessment by the nurse practitioner (NP) of the resident's Ex Order 26. 4B1 and the Ex Order 26. 4B1. The NP's Ex Order 26. 4B1 assessment indicated "copious amount of Ex Order 26. 4B1 present. Serous in nature. Close monitoring is essential. For any Ex Order 26. 4B1, increase in pain, Ex Order 26. 4B1 , odor or change in vital signs, patient should go to the Ex Order 26. 4B1 .	F 658		

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F 658	Continued From page 8 High Ex.Order 26.4(b)(1)." The NP's Ex Order 26. 4B1 assessment indicated 'Ex Order 26. 4B1. Will continue to use Ex Order 26. 4B1 for Ex Order 26. 4B1 [redacted]. Plan: Cleanse with Ex Orde apply Ex Order 26. 4B1, Ex Order pad and Ex Order 26 daily." Further review of the PO's revealed an order dated Ex.Order 26.4(b) for Ex Order 26. 4B1 [redacted] cleanse Ex Order 26. 4B1 opening with Ex Order 26. 4B1 and cover with Ex Order 26. 4B1 every 6 (six) hours. Review of the February 2023 eTAR revealed an order dated Ex.Order 26.4(b)(1 for Ex Order 26. 4B1 ution cleanse Ex Order 26. 4B1 opening with Ex Order 26. 4B1 and cover with Ex Order 26. 4B1. The order was plotted for 5:30 pm and 11:30 PM. The order for Ex Order 26. 4B1 was not transcribed onto the Ex Order 26. 4 to reflect every six hours. It was transcribed to be rendered twice a day at 5:30 pm and 11:30 pm. On 10/16/23 at 1:30 PM, the Regional Registered Nurse #1 stated that the nurses from Ex.Order 26.4(b)(1 [redacted] no longer work at the facility and were unavailable for interview. She further stated she could not speak to why the Ex Order 26. 4B1 order was changed to every six hours on 2 Ex.Order 26.4 or why the treatments were not signed as administered on Ex.Order 26.4(b)(1) On 10/16/23 at 1:45 PM, the Director of Nursing (DON) confirmed that the admitting nurse for Resident # 372 no longer worked at the facility. 10/17/23 01:31 PM, the surveyor interviewed the DON who stated "there were to many inconsistencies" and acknowledged that the Ex Order 26. 4B1 was ordered for every six hours on Ex.Order 26.4(b)(1 but plotted onto the eTAR for twice daily.	F 658		

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F 658	Continued From page 9 On 10/19/23 at 11:42 AM, the survey team met with the administrative staff. The Regional Registered Nurse #1 could not confirm if the Ex Order 26. 4B1 order should have been every six hours on admission. She also could not speak to why the Ex Order 26. 4B1 order was changed to every six hours on Ex.Order 26.4(b) and not plotted as ordered. She acknowledged that the Ex Order 26. 4B1 was not signed as administered on Ex.Order 26.4(b)(1) There was no policy provided for obtaining admission orders or for transcription of physician orders. There was no additional information provided. NJAC 8:39-11.2(b), 29.4(a)(b)	F 658		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of other facility documentation, it was determined that the facility failed to a.) ensure that a resident received the appropriate care to maintain a Ex Order 26. 4B1 consistent with professional standards of practice and b.) update the care plan for a resident with a Ex Order 26.4. This deficient practice was identified for 1	F 694	Resident #30 The care plan was added for the Ex Order 26. 4 line and the order for the Ex Order 26. 4B1 and the dressing changed were reviewed and updated to have the following orders: Ex Order 26. 4B1 all ports with Ex Order 26. of Ex Order 26. 4B1 daily. Ex Order 26. 4B1 line site for signs and symptoms of Ex.Order 26.4(b)(1) and/or Ex.Order 26.4(b)(1)	11/3/23

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F 694	Continued From page 10 of 1 resident (Resident #30) reviewed for [redacted]. This deficient practice was evidenced by the following: The surveyor reviewed the Electronic Medical Record (EMR) for Resident #30. Review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility in Ex.Order 26.4(b)(1) with diagnoses which included but was not limited to; [redacted]. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/29/23, revealed the resident had a [redacted] of [redacted], indicating that the resident was [redacted]. Further review of the MDS revealed the resident was receiving [redacted]. Review of the Order Summary Report (OSR) revealed physician orders for: '[redacted] Use [redacted] in the morning for [redacted] for 28 days, with an order date of [redacted] Use [redacted] in the afternoon for [redacted] in [redacted] for 28 Days, with an order date of [redacted]; to Change [redacted] dressing weekly one time a day every Mon for [redacted], with an order date of [redacted]."	F 694	every shift. [redacted] Ex.Order 26.4(b)(1) change on admission, weekly and PRN thereafter. [redacted] measure external [redacted] length on admission, with each [redacted] change, and PRN [redacted] change INTERMITTENT primary [redacted] every 24 hours. All the residents may be affected by this practice. The Regional Nurse Consultant and the Facility Educator will in-service all the nurses, Unit Managers, shift supervisors, Infection Preventionist, and DON in reference to writing correct picc line orders, dressing changes, flush orders and overall proper treatment and handling of picc lines The Unit Manager and/or shift supervisor will reconcile the orders of the new admissions. The Nurse transcribing the order must use the order set in the electronic medical records for all the central lines. The Infection Preventionist or designee will audit the 3 residents central line order weekly for 4 weeks then monthly for 6 months. The Infection Preventionist will submit the audit report to the administrator at the Quality Assurance Improvement meeting which meets every 3 months	

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F 694	Continued From page 11	F 694		

Further review of the OSR did not reveal a physician's order to flush the [redacted] or to change the [redacted] dressing prior to 10/02/23.

Review of the September 2023 electronic Medication Administration Record (eMAR) revealed that the [redacted] was given at 10:00 AM and the [redacted] was given at 2:00 PM and both were signed as being administered as ordered above. Further review of the eMAR did not reveal physician's order for [redacted] dressing changes or [redacted].

Review of the October 2023 eMAR revealed that the [redacted] was given at 10:00 AM and the [redacted] was given at 2:00 PM and both were signed as being administered as ordered above. Further review of the eMAR revealed the [redacted] dressing weekly one time a day every Mon for [redacted] with an order dated of [redacted], but the physician's order on the eMAR was not signed as being completed.

Review of the Care Plan revealed a Focus of "on [redacted] r/t (related to) [redacted], s/p (status post) [redacted] due to [redacted], date Initiated: [redacted]." There was no [redacted] developed and implemented for the [redacted].

On 10/13/23 at 11:38 AM, the surveyor observed a sealed envelope in a clear sleeve in Resident #30's paper chart. The outside of the envelope indicated [redacted]; send with patient." The Licensed Practical Nurse/Unit Manger (LPN/UM) verified that the envelope appeared to be unopened. The LPN/UM opened the envelope in the presence of the surveyor. There was a [redacted] card that contained the resident's

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	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 694	Continued From page 12 name, doctor, date of insertion: Ex.Order 26.4(b)(1), trimmed length: 43 cm, Ex Order 26. 4B1 . The LPN/UM verified that the Ex Order 26. 4B1 was inserted on Ex.Order 26.4(b)(1, and confirmed it was before the resident was admitted to the facility. The LPN/UM stated that the envelope should have been opened to confirm the measurements. She stated that when a resident had a Ex Order 26. 4B1 on admission, orders should be written for flushes, assessing the Ex Order 26. 4B1 Ex Order 26. 4B1, changing the dressing on admission and then weekly. The LPN/UM, in the presence of the surveyor, verified that there were no orders to flush the Ex Order 26. 4B1 and that there was not an order for Ex Order 26. 4B1 dressing changes prior to Ex.Order 26.4(b)(1). She stated flush orders were important "to keep the Ex Order 26. 4B1." She confirmed, at that time, that the Ex Order 26. 4B1 were not added to the Ex Order 26. 4B1 until Ex.Order 26.4(b)(1). She also confirmed that the Ex Order 26. 4B1 did not reflect the resident's Ex Order 26. 4 . The LPN/UM further stated that the care plan should be updated when Ex Order 26. 4B1 were started and for the care of a resident with a Ex Order 26. 4B1. On 10/13/23 at 11:57 AM, during an interview with the surveyor, Resident #30's Registered Nurse (RN) stated that when a resident was admitted with a Ex Order 26. 4B1, it should be assessed for Ex.Order 26.4(b)(1) and that it should be documented. She stated that you should call the physician to obtain Ex Order 26. 4 orders for weekly dressing changes and flushes, which are usually every shift. The RN stated that the purpose of flushing a Ex Order 26. 4B1 every shift was to keep the 'Ex Order 26. 4B1." The RN, in the presence of the surveyor, stated she was "unable to find an order for flushes." On 10/13/23 at 12:33 PM, the surveyor in the	F 694		

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F 694	Continued From page 13 presence of the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), Regional Registered Nurse (RRN) #1, and RRN #2 and discussed the above findings. RRN#1 stated the Ex Order 26. 4B1 dressings should be changed on admission and weekly and that they should be flushed "to Ex.Order 26.4(b)(1)." On 10/17/23 at 09:48 AM, the surveyor interviewed the DON and the Assistant Director of Nursing (ADON). The ADON confirmed that there were no orders for the care of Resident #30's Ex Order 26. 4B1 upon admission. On 10/17/23 at 1:30 PM, the surveyor in the presence of the survey team met with the RRN#1 RRN#2, the DON, the ADON, and the LNHA, RRN#1 who provided the surveyor an "Investigative Summary" signed by RRN#1 for Resident #30 which acknowledged that there were no physician's orders for the Ex Order 26. 4B1 care prior to Ex.Order 26.4(b)(1) There was no documented evidence to support Ex Order 26. 4B1 dressings occurred prior to Ex.Order 26.4(b)(1, no documented evidence that the Ex Order 26. 4B1 was flushed, and there was no care plan for the Ex Order 26. 4B1. Review of the facility's policy, "Physician Orders" updated 3/2023 revealed Purpose: To ensure all medications and treatment orders are received from credentialed practitioner before implementing; Process, Type of Order: 3. IV orders must be written on the appropriate IV protocol sheet (Central, Mid-line, or Peripheral). Review of the facility's policy, "Central Venous and midline Catheter Flushing" updated 1/2023 revealed Purpose: The purpose of this procedure are to maintain patency of midline and central	F 694		

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F 694	Continued From page 14 venous catheters (CVADS); to prevent mixing of incompatible medications and solutions; and to ensure entire dose of solution or medication is administered into the venous system; General Guidelines: 1. No physician order is needed for this procedure. 3. Consult state Nurse Practice Act for RN/LPN scope of practice and functions. Flushing Protocol 1. Flush catheters at regular intervals to maintain patency AND before and after the following: b. administration of medication. Documentation: The following information should be recorded in the resident's medical record: 2. Total amount of flush administered. 4. the Condition of the IV site before and after administration 7. The signature and title of person recording the data. Review of the facility's policy, "Central Venous Catheter Dressing Changes" updated 1/2023 revealed Purpose: The purpose of this procedure is to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. General Guidelines: 5. Change transparent semi-permeable membrane (TSM) dressing at least every 5-7 days and PRN (when wet, soiled, or not intact). Documentation: 1. The following information should be recorded in the resident's medical record: A. Date and time dressing was changed. B. Location and objective description of insertion site. C. Any complications, interventions that were done. F. Signature and title of the person recording the data	F 694		

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F 694	Continued From page 15 Review of the facility's policy "Care Plans, Comprehensive Person-Centered" revised 10/2022, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.	F 694		
F 695 SS=D	NJAC 8:39-25.2 (5) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to a.) ensure a physician's order was obtained for a resident receiving [redacted] and b.) the care plan was updated to include the resident was receiving [redacted]. This deficient practice was identified for 1 of 1 resident (Resident #111) reviewed for [redacted]. This deficient practice was evidenced by the following: On 10/04/23 at 12:43 PM, the surveyor observed Resident #111 awake and in bed, wearing [redacted]	F 695	Resident #111 The [redacted] order and care plan were reviewed and updated. All the residents may be affected by this practice. The Regional Clinical Nurse and the Facility Educator will in-service all the nurses, Unit Managers, and Shift Supervisors on Federal Regulation that all residents with the need for oxygen have a physician order and care plan.	11/17/23

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F 695	Continued From page 16 via Ex Order 26. 4B1. The Ex Order 26. 4B1 was set at two Ex Order 26. 4B1. The resident stated that they needed Ex Order 26. 4B1 before their admission to the facility. The surveyor reviewed the medical record of Resident #111. Review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility in Ex.Order 26.4(b)(1) with diagnoses which included but was not limited to; Ex Order 26. 4B1 [redacted]. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex.Order 26.4(b)(1) indicated that Resident #111 had a Ex Order 26. 4B1 score of [redacted] out of 15, which indicated the resident was Ex Order 26. 4B1. The Ex Order 26. [redacted] also indicated the resident used Ex Order 26. 4B1 while as a resident and while not a resident. Review of the Ex.Order 26.4(b)(1) Order Summary Report (OSR) revealed an order for "WEDNESDAY 11-7 every night shift every Wed Change Ex Order 26. 4B1 weekly, dated Ex.Order 26.4(b)(1)." Further review did not reveal a physician's order for oxygen Ex Order 26. Review of the Ex.Order 26.4(b)(1) OSR revealed a physician's order for 'Ex Order 26. 4B1 every 24 hours as needed for low Ex Order 26. 4B1 [redacted] maintain Ex Order 26. 4B1 above 89%	F 695	The Unit Managers or designee will audit the oxygen order and care plan for 3 residents a week for 4 weeks then monthly for 3 months. The Unit Managers will submit the audit report to the administrator at the Quality Assurance Improvement meeting which meets every 3 months.	

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F 695	Continued From page 17 during the day time, order date of Ex.Order 26.4(b)(1) 3, and Ex Order 26. 4B1 every shift for low Ex Order 26. 4B maintain Ex Order 26. 4B above 89%, order date of Ex.Order 26.4(b)(1)." Review of the electronic progress notes revealed a nurses note dated Ex.Order 26.4(b)(1) at 07:10 indicated, 'Ex.Order 26.4(b)(1). Received in bed, Ex Orde in place administered as ordered and tolerated, Ex.Orc ." Further review of the electronic progress notes revealed a Physician/NP (Nurse Practitioner) note dated Ex.Order 26.4(b)(1) at 19:20 indicated, ' Ex Order 26. 4B1, no *Ex Order 26. 4B1*, ..., Ex Order 26. 4B1 prn (as needed)." Review of the "Weights and Vitals Summary; Vital: Ex Orde sats" revealed that Resident #111's Ex Order 26. 4B was assessed and was documented as wearing Ex Order 26. 4B1 via *Ex Order 26. 4B1* 24 times from Ex.Order 26.4(b)(1) through Ex.Order 26.4(b)(1). Review of the care plan (CP) revealed that there was no care plan developed and implemented for Ex Order 26. 4B1 use. On 10/11/23 at 12:35 PM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that a physician's order should be obtained for a resident requiring Ex Order 26. 4B1 and the Ex Order 26. 4B1 should be added to the resident's CP. She further stated that she reviews the hospital records and updates new admission Ex Order 26. 4B1 every morning Monday through Friday to make sure they include the resident's diagnoses and goals. The LPN/UM stated the CP should reflect Ex Order 26. 4B1 related to "the diagnosis and goals of care." On 10/11/23 at 01:03 PM, in the presence of the	F 695		

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F 695	Continued From page 18 surveyor, the LPN/UM reviewed the medical record for the physician orders for Ex Order 26. 4B1 and the CP for Ex Order 26. 4B1 for Resident #111. She stated, "At this time, I am unable to locate the Ex Order 26. 4B1 order from admission and yes, Ex Order 26. 4B1 should have been care planned." The LPN/UM was unable to locate the CP. On 10/12/23 at 09:29 AM, during an interview with the surveyor, the Director of Nursing (DON) stated she reviewed Resident #111's physician orders for Ex.Order 26.4(b)(1) and verified she did not find an order for Ex Order 26. 4B1. She then stated that the purpose of a physician's order was so that nurses know how many liters of Ex Order 26. 4B1 to administer and that the resident required Ex Order 26. 4B1. The DON also stated she reviewed the CP and verified that Ex Order 26. 4B1 was not on the CP prior to 1Ex.Order 26.4(b)(1), after surveyor inquiry. On 10/13/2023 at 12:33 PM, the surveyor in the presence of the survey team met with the Licensed Nursing Home Administrator, the DON, Regional Registered Nurse (RRN) #1, and RRN#2 and discussed the above findings. RRN#1 stated that the CP should contain person centered goals, needs of the resident, "whatever we need to do, and how we care for them" (residents). She then stated that "it" (CP) should include *Ex Order 26. 4B1*. On 10/16/2023 at 08:45 AM, the facility provided an "Investigative Summary" for Resident #111 dated Ex.Order 26.4(b)(1), which acknowledged that the resident was admitted with a need for Ex Order 26. 4B1 at Ex Order 26. 4B1 via *Ex Order 26. 4B1*, that the resident used the Ex Order 26. 4B1 continuously and there was no documented evidence of a physician's order for Ex Order 26. 4B1, and that Ex Order 26. 4B1 was addressed in the	F 695		

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F 695	Continued From page 19 residents care plan after surveyor inquiry. Review of the facility's policy, "Physician Orders" updated 3/2023 revealed Purpose: To ensure all medications and treatment orders are received from credentialed practitioner before implementing. Review of the facility's policy "Oxygen Administration" revised 10/2023, revealed Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. Review of the facility's policy "Care Plans, Comprehensive Person-Centered" revised 10/2022, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. NJAC 8:39-11.2(a)(e)	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 698		11/17/23

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F 698	Continued From page 20 by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to accurately monitor a resident's *Ex Order 26. 4B1* [redacted] treatment access site. This deficient practice was identified for 1 of 1 resident (Resident #93) reviewed for Ex Order 26. 4B1. This deficient practice was evidenced by the following: On 10/12/23 at 10:10 AM, the surveyor observed Resident #93 in bed. The resident was Ex.Order 26.4 [redacted] appropriately to the surveyor. The resident stated that he/she went to *Ex Order 26. 4B1* on *Ex Order 26. 4B1* and Ex Order 26. 4B1 in the afternoon. The resident stated that the Ex Order access site was in the *Ex Order 26. 4B1* [redacted]. Review of Resident #93's Admission Record (an admission summary) reflected diagnoses which included but was not limited to; *Ex Order 26. 4B1* [redacted]. Review of the Quarterly Minimum Data Set (MDS), an assessment tool to facilitate the management of care dated 9/5/23, included a Brief Interview for Mental Status (BIMS) score of Ex Ord out of 15 which was indicative of Ex Order 26.4 [redacted]. Review of the resident's Order Summary Report (OSR) included a physician's order (PO) dated 1 Ex.Order 26.4(b) [redacted], for Ex Order *Ex Order 26. 4B1* [redacted] at 3:30 PM. It also included a PO dated 1 Ex.Order 26.4(b) [redacted],	F 698	Resident #93 The order to check the *Ex Order 26. 4B1* of the Ex Order 26. 4B1 [redacted] for *Ex Order 26. 4B1* [redacted] was discontinued. All the residents on Ex.Order 26.4(b)([redacted] may be affected by this practice. The Regional Clinical Nurse and the Facility Educator will in-service all the nurses, Unit Managers, and Shift Supervisors on writing proper orders on location and type of dialysis access site. The Unit Manager and/or shift supervisor will reconcile the orders of the new admissions. The Unit Managers or designee will audit the hemodialysis access order of all the dialysis residents weekly for 4 weeks then monthly for 6 months. The Infection Preventionist will submit the audit report to the administrator at the Quality Assurance Improvement meeting which meets every 3 months.	

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F 698	Continued From page 21	F 698		

for "Nursing staff to assess ** Ex Order 26. 4B1 [redacted] each shift and as needed * Report abnormalities to MD/ Ex Order 26. 4B1 immediately"; this order was discontinued on Ex.Order 26.4(b)(1). After surveyor inquiry the OSR included a PO dated Ex.Order 26.4(b)(1), for "Nursing staff to assess * Ex Order 26. 4B1 [redacted] dressing intact. Monitor for signs and symptoms of Ex.Order 26.4(b)(1) * Report Ex.Order 26.4(b)(1) to MD Ex Order 26. 4B1 immediately."

Review of the Physician/Nurse Practitioner Note dated Ex.Order 26.4(b)(1), included that the resident had a Ex Order 26. 4B1 in the Ex Order 26. 4B1, had Ex Order 26. 4B1 and went for Ex Order treatments Ex Order 26. 4B1 [redacted].

Review of the care plan dated Ex.Order 26.4(b)(1) reflected the resident had a 'Ex Order 26. 4B1."

On 10/13/23 at 9:13 AM, the surveyor interviewed the resident's Registered Nurse (RN) who stated the Ex Order 26. 4B1 was in the Ex Order 26. 4B1. She acknowledged that there was a PO to check the site for Ex Order 26. 4B1. The RN stated she was not sure how to assess the residents access site for Ex Order 26. 4B1. She stated the assessment usually pertained to an Ex Order 26. 4B1 which was not as deep. The RN further stated, "to tell you the truth, I cannot say if you can check Ex Order [redacted], but you must be able to hear Ex Order [redacted] because there is Ex.Order 26.4([redacted]

On 10/16/23 at 8:55 AM, the surveyor interviewed the Regional RN (RRN#1) in the presence of the survey team. She stated that the resident had a Ex.Order 26.4(b)(1) it was possible to check the Ex Order 26 [redacted].

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F 698	Continued From page 22 On 10/16/23 at 10:33 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. She stated the RRN #1 called the resident's physician who stated the resident had a Ex Order 26. 4B1 which did not require a check for Ex Order 26. 4B1. The DON acknowledged that to check for Ex Order 26. 4B1 would have been an inaccurate assessment and that the order should have been clarified. She further stated the nursing supervisor who checked the orders should have identified the error. On 10/17/23 at 1:48 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Assistant DON, RRN #1 and RRN #2 and discussed the above findings. The DON acknowledged that there was "no way to assess a Ex Order 26. 4B1" for a Ex Order 26. 4B1. RRN #1 stated that sometimes if a Ex Order 26. 4B1 was new the resident would have a temporary Ex Order 26. 4B1 for Ex Order. She further stated that it would have been appropriate to check for Ex Order 26. 4B1 for an Ex Order 26. 4B1, however the resident's Ex Order 26. 4B1 was not new and was a long-standing Ex Order 26. 4B1 site. RRN #1 stated the Licensed Practical Nurse (LPN) who transcribed the physician's order was new but should have identified that a Ex Order 26. 4B1 could not be used to assess a Ex Order 26. 4B1 and should have called the Ex Order center and the physician to clarify the order. During that same interview, the RRN #2 stated the nurses were "not looking at the site" of the Ex Order 26. 4B1 and should have realized that they could not check Ex Order 26. 4B1 on a Ex Order 26. 4B1. In addition, the DON stated the nurses thought process should have "sparked" and they should have called the physician to clarify the order to	F 698		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 23 properly assess and monitor the site. Review of the facility policy Ex Order 26. 4B1 Patients" with a revised date o Ex.Order 26.4(b)(1), included to check Ex Order 26. 4B1 or feel for a Ex Order 26. 4B1. It further included that "if you do not feel a pulse or hear a Ex Order 26, check again by placing your fingers gently over Ex Order 26. 4B and check for a Ex Order 2. Call the Ex Order 26. 4B1 unit immediately. If the unit is closed, call the MD." Review of the facility policy 'Ex Order 26. 4B1 Access Care" with a reviewed date Ex.Order 26.4(b), included 'Ex Order 26. 4B1 for Ex Order 26. 4B1 are generally inserted in the Ex Order 26. 4B1." It also included that "the dressing change is done in the Ex Order 26. 4B1 center post-treatment" and "the Ex Order 26. 4B1 must be kept clean and dry at all times." There was no evidence in the "care of Ex Order 26. 4B1 " to check for Ex Order 26. 4B1.	F 698		
F 755 SS=E	NJAC 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 755	Continued From page 24 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Complaint # NJ 00159893 Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to a.) accurately document the administration of medications in the *Ex Order 26. 4B1* b.) clarify duplicate physician's orders for an *Ex Order 26. 4B1* medication, *Ex Order 26. 4B1*, and c). failed to obtain a medication for [redacted]. This deficient practice occurred for 3 of 24 residents, (Resident #58, #112, and #220) reviewed for medication review. Reference: New Jersey Statutes Annotated, Title	F 755	Resident #220 *Ex Order 26. 4B1* *Ex Order 26. 4B1* tablet was a duplicate order and was discontinued. *Ex Order 26. 4B1* were refused and required documentation completed. Resident #58 *Ex Order 26. 4B1* every 12 hours ordered on [redacted] reviewed and provided without delay. Resident #112 The omitted documentations were reviewed and required documentations were completed for the following	

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F 755	Continued From page 25 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." This deficiency was evidenced by the following: 1. On 10/12/23 at 9:00 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN#1) in the room of Resident #220. The surveyor observed RN#1 checking the resident's identification bracelet and informing Resident #220 that she will be administering the resident's medications. The surveyor observed the resident in bed and just finished eating breakfast. On 10/12/23 at 9:05 AM, the surveyor observed	F 755	medications: *Ex Order 26. 4B1* [redacted] All the residents may be affected by this practice. The Facility Educator and Pharmacy Consultant will in-service all the nurses, Unit Managers, and Shift Supervisors on proper medication administration timing, duplicate orders, The Pharmacy Consultant will in-service the nurses monthly on consultation findings. The Pharmacy consultant will address the trend of her/his findings with the Director of Nursing and the Administrator " The Director of Nursing or designee	

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F 755	Continued From page 26 RN#1 preparing to administer five (5) medications to Resident #220 which included *Ex Order 26. 4B1* *Ex Order 26. 4B1* tablet (*Ex Order 26. 4B1*). The surveyor observed RN#1 prepared Resident #58's medications for administration and observed RN#1 removed the automated roll of the resident's daily medications. RN#1 was observed reviewing the medications and she pointed out that they were two medications that were scheduled for 6:30 AM, that was not administered. At that same time, the surveyor observed the two medications were *Ex Order 26. 4B1* and *Ex Order 26. 4B1* scheduled for 6:30 AM. RN#1 also pointed out there was a duplicate order for *Ex Order 26. 4B1*. She stated she would administer one *Ex Order 26. 4B1* and would notify the physician to discontinue one of the *Ex Order 26. 4B1*. On 10/12/23 at 10:20 AM, the surveyor interviewed RN#1 regarding the two omissions from 6:30 AM. RN#1 acknowledge the *Ex Order 26. 4B1* were not administered at 6:30 AM, but was unable to answer why the medications were not administered to Resident #220. The surveyor reviewed the medical record for Resident # 220. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to *Ex Order 26. 4B1*	F 755	will audit the medication omissions for 5 residents weekly then 10 residents monthly for 6 months. " The Director of will submit the audit report to the administrator at the Quality Assurance Improvement meeting which meets every 3 months..	

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F 755	Continued From page 27	F 755		

Ex Order 26. 4B1 [redacted]

A review of the Admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated Ex.Order 26.4(b)(1) reflected that the resident's Ex Order 26. 4B1 [redacted] score was [redacted] out of 15, which indicated that the resident was Ex Order 26. 4B1 [redacted].

A review of the Ex.Order 26.4(b)(1) Order Summary Report (OSR) revealed a Ex Order 26. 4B1 [redacted] dated Ex.Order 26.4(b)(1) for the following medications:
- Ex Order 26. 4B1 [redacted], give 1 tablet by mouth one time a day for Ex Order 26. 4B1 [redacted],
- Ex Order 26. 4B1 [redacted] by mouth one time a day for Ex Order 26. 4B1 [redacted] take on an empty stomach,
- Ex Order 26. 4B1 [redacted], give 1 tablet by mouth one time a day for Ex Order 26. 4B1 [redacted] and
- Ex Order 26. 4B1 [redacted], give 1 tablet by mouth one time a day for Ex Order 26 [redacted] may increase the risk of bleeding. Please observe for any Ex.Order 26.4(b)(1) [redacted]

A review of the Ex.Order 26.4(b)(1), electronic medication administration record (eMAR) revealed an order for Ex Order 26. 4B1 [redacted] delayed release Ex Order 26. 4B1, give 1 tablet by mouth one time a day for Ex Order 26. 4B1 [redacted] scheduled for 6:30AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 755	Continued From page 28	F 755		

revealed that the nurse did not sign the eMAR on Ex.Order 26.4(b)(1) at 6:30 AM as administered.

A review of the Ex.Order 26.4(b)(1) eMAR revealed an order for *Ex Order 26. 4B1* , give 1 tablet by mouth one time a day for *Ex Order 26. 4B1* take on an empty stomach scheduled for 6:30 AM, revealed that the nurse did not sign the eMAR on Ex.Order 26.4(b)(1) at 6:30 AM as administered.

A review of the Ex.Order 26.4(b)(1) eMAR revealed two orders of *Ex Order 26. 4B1* , give 1 tablet by mouth one time a day for Ex Order 26. scheduled for 8:00 AM, revealed that on Ex.Order 26.4(b)(1) , both orders of Ex Order 26. 4B1 were documented as being administered.

On 10/16/23 at 1:10 PM, the surveyor in the presence of the survey team met with the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA), Regional Clinical Registered Nurse (RCRN#1) and RCRN#2 and discussed the above findings.

On 10/16/23 at 1:25 PM, the surveyor attempted to conduct a telephone interview with the nurse who omitted the 6:30 AM medication on Ex.Order 26.4(b)(1), but was unable to conduct an interview.

On 10/17/23 at 1:30 PM, the DON acknowledge there was a duplicate order for *Ex Order 26. 4B1* and that this double order should have been discontinued on Ex.Order 26.4(b)(1). She stated that despite that Ex Order 26. 4B1 was signed as administered twice on Ex.Order 26.4(b)(1) , the nurses did not administer a double dose. The DON also confirmed that the nurse omitted documenting the eMAR for *Ex Order 26. 4B1* on Ex.Order 26.4(b)(1)3. She stated that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 755	Continued From page 29	F 755		

resident refused the medications and the nurse failed to document that the resident refused the two medications.

On 10/19/23 at 10:20 AM, the surveyor interviewed RN#1 regarding Resident #220's double dose of [redacted] and the procedure of discontinuing a double order. RN#1 stated that when a double order of a medication is noticed on the eMAR, a nurse should get a discontinued order for one of the medications and that should be done immediately.

2. On 10/5/23 at 10:30 AM, the surveyor observed Resident #58 in bed with their eyes closed.

The surveyor reviewed the medical record for Resident # 58.

A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to *Ex Order 26. 4B1* [redacted].

A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], reflected the resident's *Ex Order 26. 4B1* [redacted] score was [redacted] out of 15, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 755	Continued From page 30 indicated that the resident was Ex Order 26. 4B1 [redacted]. A review of the Ex.Order 26.4(b)(1) Physician's Orders (PO) revealed a Ex Order 26. 4B1 dated 02/04/22 for Ex Order 26. 4B1 [redacted] give 1 tablet ([redacted]) by oral route every 12 hours for [redacted]. A review of the Ex.Order 26.4(b)(1) eMAR revealed an order for Ex Order 26. 4B1 [redacted], extended release give 1 tablet ([redacted]) by oral route time every 12 hours scheduled for 9 AM and 9 PM. Further review of the eMAR revealed the Ex Order 26. 4B1 [redacted] was not administered due to the medication not being available on the following dates and times: - 9/5/22 at 9PM, - 9/6/22 at 9AM, - 9/6/22 at 9PM, - 9/7/22 at 9AM and - 9/7/22 at 9PM. A review of the Ex.Order 26.4(b)(1) progress notes revealed the following nursing note dated on [redacted] at 12:54 AM indicating, 'Ex Order 26. 4B1 [redacted] (standing order every 12 hours) unavailable at this time and no back up supply in the Ex Order 26. 4B1 [redacted]. Patient has a history of [redacted]. Patient resting at this time. Vitals Ex.Order 26.4(b)(1) [redacted] at this time. -11 PM- MD notified by writer that medication is unavailable and none in back up Ex Order 26. 4B1 at this time. MD explained to writer that a new script will be provided for 9/7/22 and no new orders at this	F 755		

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	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 755	Continued From page 31 time is necessary." On 10/16/23 at 10:00 AM, the DON informed the surveyor that the nurse who wrote the Ex.Order 26.4(b) progress note no longer works for the facility. The surveyor was unable to conduct an interview with that nurse. On 10/17/23 at 1:25 PM, the surveyor met with the DON, LNHA, Assisted Director of Nursing, RCRN#1 and RCRN#2 and discussed the above findings. On 10/18/23 at 10:15 AM, the surveyor interviewed Resident #58 who stated that he/she was unable to recall if he/she was experiencing any Ex.Order 26.4(b)(1) in Ex.Order 26.4(b)(1) but has no issues with Ex.Order 26 at this time. On 10/18/23 at 1:35 PM, the ADON acknowledged that the resident went without their *Ex Order 26. 4B1* from 9:00 PM on Ex.Order 26.4(b) through 9 PM on Ex.Order 26.4(b)(1) She stated that the facility was in communication with the pharmacy and that they attempted to call the physician who was unavailable. When the surveyor requested this documentation, she presented the above nursing note from Ex.Order 26.4(b)(1) 12:54 AM. The surveyor requested the documentation showing the facility was calling the pharmacy and the physician prior to Ex.Order 26.4(b) and the surveyor was told that the facility had no documentation. 3). On 10/4/2023 at 12:36 PM the surveyor observed, resident #112 resting in bed, awake, alert and offered no concerns. Resident's	F 755		

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	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 755	Continued From page 32	F 755		

daughter at bedside.

The surveyor reviewed the medical record for Resident #112.

A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses that included but not limited to [redacted].

A review of Admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident's [redacted] score was [redacted] out of 15, which indicated that the resident's cognition was [redacted]. [redacted] indicated that the resident was receiving [redacted] prior to admission and while a resident within the facility.

A review of the August, September, and October 2023 OSR and eMAR revealed the following:

1. An order dated [redacted] for [redacted] by mouth three times a day for [redacted] with plotted time of 9AM, 1500 (3 PM), and 2100 (9 PM) which revealed the following omissions: [redacted]

2. An order dated [redacted] for [redacted] by mouth one time a day for [redacted] with plotted time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

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F 755	Continued From page 33 of 9AM which revealed the following omissions: Ex.Order 26.4(b)(1) 3. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* , apply to Ex.Order 26.4(b)(1) one time a day for Ex.Order 26.4(b)(1) with plotted time of 9 AM which revealed the following omissions: Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) 4. An order dated Ex.Order 26.4(b)(for *Ex Order 26. 4B1* , give one tablet by mouth at bedtime for *Ex Order 26. 4B1* with plotted time of 2100 (9 PM) which revealed the following omissions: Ex.Order 26.4(b)(1) 5. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* , give one tablet by mouth in the morning for *Ex Order 26. 4B1* with plotted time of 9 AM which revealed the following omissions: Ex.Order 26.4(b)(1) Ex.Order 26.4(b)(1) 6. An order dated 8 Ex.Order 26 3 for *Ex Order 26. 4B1* , give one tablet by mouth one time a day every *Ex Order 26. 4B1* for *Ex Order 26. 4B1* with plotted time of 9 AM which revealed the following omissions: Ex.Order 26.4(b)(. 7. An order dated Ex.Order 26.4(b)(for *Ex Order 26. 4B1* by mouth every 12 hours for *Ex Order 26. 4B1* with plotted time of 9 AM and 9 PM which revealed the following omissions: Ex.Order 26.4(b)(at 2100 (9 PM). 8. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* , give one tablet by mouth two times a day for *Ex Order 26. 4B1* with plotted time of 9 AM and 1700 (5 PM) which revealed the following omissions: Ex.Order 26.4(b)(at 1700 (5 PM).	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 34 9. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* [redacted], give one capsule by mouth two times a day of *Ex Order 26. 4B1* with plotted time of 9 AM and 1700 (5 PM) which revealed the following omissions: Ex.Order 26.4(b)(1) at 9 AM, Ex.Order 26.4(b)(1) at 1700 (5 PM) Ex.Order 26.4(b)(1) at 1700 (5 PM) 10. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* [redacted], give one tablet by mouth every 12 hours for *Ex Order 26. 4B1* with plotted time of 9 AM and 2100(9 PM) which revealed the following omissions: Ex.Order 26.4(b)(1) at 2100 (9 PM) Ex.Order 26.4(b)(1) at 9 AM Ex.Order 26.4(b)(1) at 2100 (9 PM) Ex.Order 26.4(b)(1) at 9 AM Ex.Order 26.4(b)(1) at 2100 (9 PM) 11. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* [redacted], give one tablet by mouth three times a day for *Ex Order 26. 4B1* with plotted time of 9 AM, 1500 (3 PM), 2100 (9 PM) which revealed the following omissions: Ex.Order 26.4(b)(1) at 9 AM 12. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* [redacted], give one tablet by mouth every eight hours for Ex.Order 26. with plotted time of 6 AM, 1400 (2 PM), and 2200 (10 PM) which revealed the following omissions: Ex.Order 26.4(b)(1) at 6 AM Ex.Order 26.4(b)(1) at 6 AM Ex.Order 26.4(b)(1) at 1400 (2 PM) Ex.Order 26.4(b)(1) at 2200 (10 PM) Ex.Order 26.4(b)(1) at 1400 (2 PM) 13. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1*	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

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F 755	Continued From page 35	F 755		

Ex Order 26. 4B1, give one tablet by mouth every six hours for Ex Order 26. 4B1 with the plotted time of 0000 AM, 6 AM, 12 PM and 1800 (6 PM) which revealed the following omissions:
Ex.Order 26.4(b)(1 at 12 PM
Ex.Order 26.4(b)(1 at 6 AM
Ex.Order 26.4(b)(1 at 12 AM
Ex.Order 26.4(b)(1 at 6 AM
Ex.Order 26.4(b)(1 at 12 PM
Ex.Order 26.4(b)(1 at 1800 (6 PM)
Ex.Order 26.4(b)(1 at 1800 (6 PM)

14. An order dated Ex.Order 26.4(b)(1 for Ex Order 26. 4B1 [redacted] UNIT, give one capsule by mouth before meals and at bedtime for Supplement with the plotted time of 07:30 AM, 11:00 AM, 1600 (4 PM) and 2100 (9 PM) which revealed for following omissions:
Ex.Order 26.4(b)(1 at 11:00 AM
Ex.Order 26.4(b)(1 at 1600 (4 PM)
Ex.Order 26.4(b)(1 at 2100 (9 PM)
Ex.Order 26.4(b)(1 at 1600 (4 PM)
Ex.Order 26.4(b)(1 at 11 AM

15. An order dated Ex.Order 26.4(b) for Ex Order 26. 4B1 [redacted], instill one drop in both Ex Order 26 two times a day for Ex Order 26. 4B1 with the plotted time of 8 AM and 2000 (8 PM) which revealed the following omissions:
Ex.Order 26.4(b)(1 at 8 AM
Ex.Order 26.4(b)(1 at 2000 (8 PM)
Ex.Order 26.4(b)(1 at 8 AM

16. An order dated Ex.Order 26.4(b)(1) for Ex Order 26. 4B1 [redacted], insert 1 application Ex Order 26. 4B1 one time a day for Ex Order 26. 4B1 for 1 day with the plotted time of 6:30 AM on Ex.Order 26.4(b)(1) which revealed the following omissions:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

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F 755	Continued From page 36	F 755		

Ex.Order 26.4(b)(1)

17. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* [redacted], give one tablet by mouth at bedtime for *Ex Order 26. 4B1* with the plotted time of 2100 (9 PM) which revealed the following omissions: Ex.Order 26.4(b)(1)

18. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* [redacted], given one tablet by mouth every eight hours for *Ex Order 26. 4B1* with the plotted time of 6 AM, 1400 (2 PM), 2200 (10 PM) which revealed the following omissions:
Ex.Order 26.4(b)(1) at 1400 (2 PM)
Ex.Order 26.4(b) at 6 AM

19. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* [redacted], give one tablet by mouth at bedtime for *Ex Order 26. 4B1* ADMINISTER WITH Ex.Order 26.4B1 [redacted] TO EQUAL *Ex Order 26. 4B1* with the plotted time of 2100 (9 PM) which revealed the following omissions: Ex.Order 26.4(b)(1)

20. An order dated Ex.Order 26.4(b)(1) for *Ex Order 26. 4B1* [redacted] give one tablet by mouth at bedtime for *Ex Order 26. 4B1* ADMINISTER WITH Ex.Order 26.4B1 [redacted] TO EQUAL *Ex Order 26. 4B1* TOTAL with the plotted time of 2100 (9 PM) which revealed the following omissions: Ex.Order 26.4(b)(1)

On 10/17/23 at 09:42 AM, the surveyor interviewed the License Practical Nurse (LPN#1) who stated that she is an agency nurse and had been working at the facility for Ex.Order 26.4(b)(1). The LPN#1 stated if a resident refuses medication, then "I will let my supervisor know or check with the resident again after ten minutes."

10/17/23 at 09:56 AM, the surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 755	Continued From page 37	F 755		

LPN#2 who stated that she is an Agency Nurse, and this was Ex.Order 26.4(b)(1) on the unit and the Ex.Order 26.4(b)(1) at this facility. The surveyor interviewed the Nurse about the medication administration process. She stated, "I knock on the resident's door, check the *Ex Order 26. 4B1* first for *Ex Order 26. 4B1* medication, then check the resident's Identification band or picture on the computer to make sure it is the right patient. I then administer medication and make sure they swallow their medications. I then wash my hands afterwards. If the resident is sleeping, I awaken the resident and tell them it's time for their medication. If they don't want to take it at that time, I then check back with them." The surveyor asked LPN#2 to explain the process of documenting on the eMAR, specifically what it means when the medication administration box is empty and she stated, "if it is not signed off, means it wasn't given."

10/17/23 10:05 AM, the surveyor interviewed LPN#3/Unit Manager (LPN#3/UM) regarding omissions on Resident #117's eMAR. The surveyor and LPN#3/UM reviewed the resident's eMAR from August and September 2023 which revealed multiple omissions. LPN#3/UM stated, "I do not know if the medications were given or not." She further stated that the nurses should document if a medication was given or not given. It was not acceptable practice for not documenting on the eMAR and it's the nurse's responsibility to document the eMAR if the medication was given or refused.

On 10/18/2023 at 12:33 PM, The surveyor interviewed the Consultant Pharmacist (CP) via the telephone, in the presence of the survey team. The CP stated that she comes to the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

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F 755	Continued From page 38	F 755		

once a month to review the residents' charts. She stated her responsibilities included checking for irregularities, observing med pass, unit inspections, chart reviews and providing in-service when needed. The surveyor asked the CP what is the process if she observes omissions on the medication administration records. She stated, "I let the nurses know if there are omissions on the medications administration record that are infrequent and if there are frequent omissions, I then report it to the Director of Nursing because it is a trend, and they need to investigate it." She further stated that she also communicates her findings to the Director of Nursing and Administrator via a written report.

The surveyor requested the written copy of the Pharmacy Consultant report which she provided to the surveyor on 10/18/2023 at 1:51 pm.

Review of the Pharmacy Consultant Report dated Ex.Order 26.4(b)(1), indicated in the facility wide that charting gaps were noted.

10/19/23 at 12:12 PM, the surveyor in the presence of the survey team met with the LNHA, RRN#1, RRN#2, DON, ADON, and Regional Social Worker and discussed the above findings. The RRN#2 stated, "There are bunch of refusal notes in the Electronic Medication Administration Record." She further stated, "They are writing stuff in here instead of writing a separate note."

A review of the facility's policy for "Documentation of Medication Administration" updated 10/2019, which was provided by Regional Registered Nurse #1 (RRN #1) included the following, "A nurse of certified Medication Aide (Where applicable) shall document all medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 39 administered to each resident on the resident's medication administration record (MAR). Administration of medication must be documented immediately after (never before) it is given. Documentation must include name, strength of the drug, dosage, method of administration, date and time of administration, reason why a medication was withheld, not administered, or refused; signature and title of the person administering the medication; and Resident's response to the medication, if applicable." A review of the facility's policy for "Administering Medication" dated 10/31/22, which was provided by the DON included the following: "If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication will document in medication administration record". A review of the facility's policy for "Charting and Documentation" dated 03/31/20, which was provided by the DON included the following: "The following information is to be documented in the resident medical record b. Medication administered."	F 755		
F 757 SS=D	NJAC 8:39-11.2 (b), 29.2 (d) Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 757	Continued From page 40 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documents it was determined that the facility failed to provide adequate indications and documentation supporting the rationale for Ex Order 26. 4B1 related medications for a resident who Ex Order 26. 4B1 for Ex Order 26. 4B1. This deficient practice was identified for 1 of 24 residents (Resident #99) reviewed during medical record review and was evidenced by the following: On 10/5/23 at 10:00 AM, the surveyor observed Resident #99, self-propelling in their wheelchair toward the bathroom. The resident was alert and oriented but did not want to be interviewed. The surveyor observed the resident's room which had no stop sign or Ex Order 26. 4B1 signage on the door or wall, and no personal protection equipment (PPE) bin located outside of the resident's room.	F 757	Resident #99 The physician and Nurse Practitioner were notified immediately and Ex Order 26. 4B1 were discontinued. The Ex Order 26. 4B1 precaution was discontinued immediately. All the residents may be affected by this practice. " The Director of Nursing, Facility Educator, and Infection Preventionist will in-service all the nurses, Unit Managers, and Shift Supervisors on reviewing proper clinical criteria prior to calling physician, ensuring proper communication between staff, and ensuring orders are correct.	

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	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

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F 757	Continued From page 41 The surveyor reviewed the medical record for Resident # 99. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to *Ex Order 26. 4B1* [redacted]. A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated Ex.Order 26.4(b)(1) reflected that the resident's Brief Interview for Mental Status score was [redacted] out of 15, which indicated that the resident was *Ex Order 26. 4B1*. A review of the Ex.Order 26.4(b)(1) Order Summary Report (OSR) and the resident's Ex.Order 26.4(b)(1) electronic medication administration record (eMAR) revealed the following physician's orders (PO) dated [redacted] for the following medications: -*Ex Order 26. 4B1* [redacted], give 1 tablet by mouth two times a day for *Ex Order 26. 4B1* for 5 days, scheduled on the eMAR for 9 AM and 5 PM. -*Ex Order 26. 4B1* [redacted], give 1 tablet by mouth one time a day for *Ex Order 26. 4B1* for 6 days, scheduled on the eMAR for 9 AM.	F 757	" The Unit Managers will keep the [redacted] Testing Logbook in the unit. " The Infection Preventionist will check the *Ex Order 26. 4B1* test logbook daily. " The Nurses will utilize the new log test form for residents [redacted] testing and will be filed in the [redacted] test logbook. " The Infection Preventionist will send out a weekly updated isolation list to all the department heads via email and hard a copy report. " The *Ex Order 26. 4B1* or designee will audit the 5 [redacted] test weekly then monthly for 6 months. " The *Ex Order 26. 4B1* will submit the audit report to the administrator at the Quality Assurance Improvement meeting which meets every 3 months.	

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	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 757		F 757		

Continued From page 42

-Ex Order 26. 4B1 1 Ex.Order 26.4(b)(1) four times a day for Ex Order 26. 4B1 for 14 days, scheduled on the eMAR for 9 AM, 1 PM, 5 PM, and 9 PM.

-Ex Order 26. 4B1, give 1 capsule by mouth three times a day for Ex.Order 26.4(b)(1) for 14 days, scheduled on the eMAR for 9 AM, 3 PM, and 9 PM.

A review of Resident #99's progress notes (PN) revealed the following nursing note dated Ex.Order 26.4(b)(1) at 3:30 PM which revealed the following documentation, 'Ex Order 26. 4B1, alert, verbally responsive, able to make needs known, no distress noted, Ex Order 26. 4B1 Ex.Order 26.4(b), Ex Order 26. 4B1 Ex.Order 26.4(b), Ex Order 26. 4B1 100%. NP [nurse practitioner] visited new order noted, for Ex Order 26. 4B1 [twice a day] for 5 days, Ex Order 26. 4B1 po x 6 days, Ex Order 26. 4B1 x 7 days and Ex Order 26. 4B1 [three times a day] for 14 days, orders carried out."

On 10/05/23 at 10:25 AM, the surveyor observed Resident #99's room in the presence of the Regional Registered Nurse (RRN#1) . The RRN#1 acknowledged that the resident had no stop sign or signage indicating that the resident was under strict Ex Order 26. 4B1 for Ex Order 26. 4B1, and that there was no PPE bin outside of the resident's room. The RRN#1 stated that the resident was Ex Order 26. 4B1 for Ex Order 26. 4B1 which was confirmed by the Registered Nurse/Unit Manager (RN/UM).

On 10/05/23 at 10:30 AM, the surveyor interviewed the Unit Ex RN/UM, who stated that she got a report of all the residents who were Ex Order 26. 4B1 on her unit, and further stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 757	Continued From page 43	F 757		

that she had no confirmation that Resident #99 was Ex Order 26. 4B1 for Ex Order 26. 4B1.

On 10/05/23 at 10:35 AM, the surveyor interviewed the Director of Nursing (DON) who was present on Unit Ex. Order 26. 4B1. The DON stated that the resident was not Ex Order 26. 4B1. She stated that she had a list of all the residents who were Ex Order 26. 4B1 in the facility and Resident #99 was not on that list.

At that same time, the surveyor reviewed Resident #99's Ex Order 26. 4B1 in the presence of the DON, RRN#1 and the RN/UM. After reviewing the resident's medical record, the DON and RRN#1 stated that they would retest the resident and obtain a physician's order to put the resident on Ex Order 26. 4B1.

On 10/05/23 at 10:45 AM, the surveyor observed the result for the Ex Order 26. 4B1 for Resident #99 in the presence of the RN/UM. The rapid Ex Order 26. 4B1 test revealed that the resident was Ex Order 26. 4B1 for Ex Order 26. 4B1.

On 10/05/23 at 12:43 PM, the surveyor interviewed the facility infection preventionist (IP) who stated that she tested Resident #99 on Ex.Order 26.4(b)(1) and that the resident tested Ex Order 26. 4B1 for Ex Order 26. 4B1. The IP stated that the process for tracking resident Ex Order 26. 4B1 testing was to print out the midnight census and to write all the test results on the census sheet. All the residents who tested negative had a check mark to the left of their names while all the positive residents had a plus mark. The IP showed the surveyor a copy of the Ex.Order 26.4(b)(1) midnight census which showed a check mark to the Ex Order of Resident #99's name. The IP stated she did not know how the Licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

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F 757	Continued From page 44 Practical Nurse (LPN), or the Nurse Practitioner (NP) concluded that the resident was Ex Order 26. 4B1 . The IP provided a copy of the midnight census with the test result to the surveyor. On 10/05/23 at 1:45 PM, the surveyor conducted a telephone interview with the NP in the presence of the survey team. The NP stated that she received a phone call from the LPN on 1 Ex.Order 26.4(b and was told that Resident #99 tested Ex Order 26. 4B1 for Ex Order 26. 4B1 . At that time, she gave a telephone order for four medications which included Ex Order 26. 4B1 . The NP told the surveyor that Resident #99 had multiple Ex Order 26. 4B1 and that she wanted to start the resident on medications right away. The NP further stated that she saw the resident earlier in the day and that the resident tested Ex Order 26. 4B1 . She stated that she discontinued all the medications and Ex Order 26. 4B1 precautions but since the resident had a Ex.Order 26.4(b)(1), she ordered a Ex Order 26. 4B1 to rule out any potential issues. On 10/05/23 at 2:15 PM, the surveyor conducted a telephone interview with the Licensed Practical Nurse (LPN). The LPN stated that she came to work on Ex.Order 26.4(b)(1) and a staff member informed her that Resident #99 test Ex Order 26. 4B1 for Ex Order 26. 4B1 . She was unable to speak to which staff member relayed that information. She also acknowledged that she did not see the resident's test results. She stated that there was a stop sign and signage for Ex Order 26. 4B1 and a PPE bin outside of the resident's room. She further stated that the NP came to her unit on Ex.Order 26.4(b)(1 , and asked her if any of her residents were Ex.Order 26.4(b)(1 and she told the NP that Resident #99 was Ex Order 26. 4B1 and that the NP wrote new orders for the resident.	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

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F 757	Continued From page 45 On 10/05/23 at 3:00 PM, the surveyor discussed the above findings to the facility administrative team which included the DON, Licensed Nursing Home Administrator, RRN#1, IP and the Assistant Director of Nursing. On 10/10/23 at 10:00 AM, the surveyor in the prescence of the survey team met with the administrative staff. The DON confirmed and stated that they did not have an effective system in place to ensure that the facility was communicating a list of *Ex Order 26. 4B1* residents from shift to shift. She acknowledged that this was what led to Resident # 99 being misdiagnosed as being *Ex Order 26. 4B1* . A review of the facility's policy for Charting and Documentation dated 3/31/20 and provided by the DON included that "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." NJAC 8:39-29.2 (d)	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

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F 761	Continued From page 46 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a). secure medications in 1 of 4 nursing units inspected, b). secure medications in 1 of 4 emergency kits (E-kits) inspected, and c). properly label, store and dispose of medications in 3 of 10 medication carts and 1 of 4 medication rooms inspected. This deficient practice was evidenced by the following: 1. On 10/05/23 at 2:10 PM, the surveyor observed two bags containing medications on the A unit nursing station, no residents were in the vicinity. The two bags included the following medications: Eliquis (blood thinner), Tessalon (medication for coughing), Vitamin D (vitamin), Norvasc (blood pressure), Diltiazem (blood pressure), Tradjenta (diabetes), Carafate (stomach medication), Xarelto (blood thinner), Nadolol (blood pressure) and Sevelamer (phosphate binder).	F 761	The following medications were disposed and ordered a replacement: " Eliquis " Tessalon " Vitamin D " Norvasc " Trajenta " Carafate " Xarelto " E kit-lock replaced " Expired syringe " Nebulizer tubing " e-kit with broken seal " storage of expired items " Humulog Insulin pen " Blood glucose strips " Neurontin solution All the residents may be affected by this practice. The DON in-service will all the nurses on	

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	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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F 761	Continued From page 47 At that same time, the surveyor interviewed a Licensed Practical Nurse (LPN #1) who stated that the medications inside the two bags were discontinued medications that were going to be returned to the pharmacy. LPN #1 also stated that the two bags containing the medication should not have been kept in an unsecure area and that all medication returns should have been brought to the Director of Nursing's (DON) office and placed into a locked box. On 10/05/23 at 2:20 PM, the surveyor interviewed both the DON and the Regional Registered Nurse (RRN#1), who both acknowledged that all medications should be kept in a secured locked storage area and further acknowledged that all return medications should be brought to the DON's office and placed in a locked storage box. 2. On 10/13/23 at 12:10 PM, the surveyor inspected the E-kit on the 2nd-floor subacute unit in the presence of the LPN /Unit Manager (LPN#/UM#1). The surveyor observed the E-Kit had a broken green tie-lock. At that time, the surveyor interviewed the LPN/UM#1 who acknowledged that the E-kit tied lock was broken and that once opened, it should be brought down to the DON's office and should have been replaced with a new E-kit. The E-Kit box contained the following medications: 1. Dexamethasone 10mg/ml injection (2 vials) 2. Dextrose 50% injection (one) 3. Diphenhydramine injection 50 mg (two) 4. Epinephrine 0.3 injection (one)	F 761	proper storage of all medication and disposing of expired medications. The 7-3 shift Charge Nurse will check their own assigned medication, treatment carts and e-kits daily. The pharmacy provider will set up twice a week pick up schedule for all the discontinued and expired medications. The Unit Manager and/or designee will audit all the medication cart, treatment cart, e-kit, and medication refrigerator weekly X 4 weeks then monthly X 3 months. The Unit Manager and/or designee will submit the audit report to the administrator at the Quality Assurance Improvement meeting which meets every 3 months.	

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F 761	Continued From page 48 5. Glucagon Kit 1 mg (one) 6. Glucose-15 40% gel (two) 7. Lidocaine 1% 50 ml multi-dose vial (two) 8. Methylprednisolone 40 mg/ml injection (two) 9. Narcan 4mg/0.1 Nasal Spray (two) 10. Nitroglycerin 0.4 mg sublingual tablets (25 tablets) A review of the E-Kit contents revealed no missing medications and all medications were accounted for inside the E-Kit. 3. On 10/13/23 at 9:15 AM, the surveyor inspected the medication cart #2 on the Vent unit in the presence of LPN/UM#2. The surveyor observed an expired syringe with an expiration date of 07/25/23. At that time, the surveyor interviewed LPN/UM#2 who acknowledged that the syringe had an expiration date of 07/25/23 and that the expired syringe should have been removed from the medication cart. On 10/13/23 at 11:15 AM, the surveyor inspected the medication room on the A-wing in the presence of the Registered Nurse (RN/UM #1). The surveyor observed a bag of nebulizer tubing with an expiration date of 9/17/23. At that time, the surveyor interviewed RN/UM#1 who acknowledged that the bag of nebulizer tubing was expired and should have been removed from the active medication stock. On 10/13/23 at 12:10 PM, the surveyor inspected the second subacute unit medication cart #3 in the presence of LPN/UM#1. The surveyor observed an opened Humalog insulin pen (medication for diabetes) that had no opened	F 761		

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	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 761	Continued From page 49	F 761		

date. At that time, the surveyor interviewed LPN/UM#1 who stated that once an insulin syringe was opened, there should have been an opened date.

On 10/13/23 at 12:20 PM, the surveyor inspected the B-unit A side low side medication cart in the presence of LPN/UM#3. The surveyor observed a bottle of Blood Glucose test strips that was opened and not dated and a bottle of Neurontin 250mg/5ml solution (medication for seizures) with a label to store in the refrigerator.

At that time, the surveyor interviewed LPN/UM#3 who stated that an opened bottle of Glucose blood strips should have been dated and that a bottle of Neurontin solution should have been stored in the medication refrigerator.

A review of the Manufacturer's Specifications for the following medications revealed the following:

1. Humalog insulin pen once opened have an expiration date of 28-days.
2. Glucose blood strips once opened have an expiration date of 90-days
3. Neurontin solution should be stored in the refrigerator.

On 10/16/23 at 1:30 PM, the surveyor discussed the above observations and findings with the administrative team which included the DON, Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), RRN #1 and the RRN #2.

There was no additional information provided.

A review of the facility's policy for Storage of

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F 761	Continued From page 50 Medications dated 1/31/22 and provided by the DON included that "Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity control. Only person authorized to prepare and administer medications have access to locked medications." "Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed." "Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended." "Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured locations. Medications are stored separately from food and are labeled accordingly." NJAC: 8:39-29.4 (a) (h) (d)	F 761		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		11/17/23

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F 842	Continued From page 51 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

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F 842	Continued From page 52 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint # NJ 00162720 Based on interviews and review of medical records, it was determined that the facility failed to maintain medical records accurately and completely in accordance with acceptable standards and practice by not documenting pertinent clinical documentation on the resident's medical record for a resident who had a change in condition. This was identified for 1 of 8 residents (Resident # 372) reviewed for closed records. This deficient practice was evidenced by the following: On 10/16/23 at 12:57 PM, the surveyor reviewed the closed medical record for Resident # 372.	F 842	Resident #372 was discharged on [redacted]. All the residents may be affected by this practice. " The Regional Clinical Nurse and the Facility Educator will in-service all the nurses on proper documentation on all clinical changes in residents medical chart. " The Nurse transferring the resident to the hospital will complete the Change in Condition assessment. " The Director of Nursing and/or designee will audit all the acute discharged weekly for 4 weeks than 10 residents monthly for 5 months. " The Infection Preventionist will submit	

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F 842	Continued From page 53 Review of the Face Sheet (an admission record) revealed Resident # 372 was admitted to the facility on [redacted], with diagnosis which included but not limited to [redacted]. Review of the electronic progress notes dated [redacted], timed at 1:57 AM and documented by a Licensed Practice Nurse (LPN#1) indicated "Pt [patient] [redacted]." Review of the electronic progress notes dated [redacted] and timed at 2:08 AM and documented by LPN #1 indicated a "Nursing Shift Assessment." The assessment revealed the resident's vital signs: [redacted] was [redacted], [redacted] was [redacted] beats per minute, [redacted] were [redacted] was [redacted] Fahrenheit, [redacted] and [redacted] was [redacted] The progress note reflected the resident had no early warning signs of [redacted] at this time. Review of the electronic progress notes dated [redacted] and timed at 9:45 AM and documented by LPN #2 indicated "Resident c/o [complaining of] [redacted] room air, primary nurse made aware/MD [medical doctor] made	F 842	the audit report to the administrator at the Quality Assurance Improvement meeting which meets every 3 months.	

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F 842	Continued From page 54 aware-new orders as follow- Ex Order 26. 4B1 stat [immediately], 1x [one time] order for Ex Order 26. 4B1 , stat Ex Order 26. 4B1 , recheck Ex Order 26. in 1 [one] hour after administration -orders carried out." Review of the electronic progress notes dated Ex.Order 26.4(b), and timed at 10:29 AM indicated documentation from the activities department "Delivered daily chronicle to (Resident # 372) along with updated activity calendars for February, encouraged to come to activities." Review of the electronic progress notes dated Ex.Order 26.4(b), and timed at 3:31 PM indicated documentation from the Ex Order 26. 4B1 department "Treatment withheld today due to pt [patient] stating Ex Order 26. 4B1 .' Patient receiving Ex Order 26. 4B1 at the time. Per nursing, Pt also had elevated Ex Order 26. 4B1 . Pt approached in the afternoon and refused Ex Order 26. 4B1 , stating 'Ex Order 26. 4B1 .' Further review of the electronic progress notes dated Ex.Order 26.4(b)3, and timed at 10:33 PM indicated "Call made to Ex.Order 26.4(b)(1) for follow up. Pt [patient] admitted with Ex Order 26. 4B1 due to Ex Order 26. 4B1 ." There was no documented evidence of a change in the resident's clinical condition which resulted in transferring the resident to the hospital including vital signs, notifying the doctor and family. Review of the New Jersey Universal Transfer Form (UTF) dated Ex.Order 26.4(b)(1) the resident was transferred at Ex Order 26. 4B1 . The UTF did not	F 842		

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F 842	Continued From page 55 indicated the reason for transfer or where the resident was transferred to. Review of the hospital records Ex.Order 26.4(b)(1) and timed at 7:45 PM indicated that the resident presented to the Ex Order 26. 4B1 via Ex Order 26. 4 ambulance with "a chief complaint of Ex Order 26. 4B1 along with Ex Order 26. 4B1 since 8 am." On 10/19/23 at 11:42 AM, the surveyor interviewed the Regional Registered Nurse #1 who stated, "the nurse should have documented what happened with the resident when sent to the hospital." She further stated there was documentation the morning of Ex.Order 26.4(b), that there was a change in condition and the doctor was notified and new orders were obtained but there was no further documentation of the resident's clinical condition which led to hospitalization. Review of the facility policy titled "Acute Condition Changes-Clinical Protocol" revised 1/2023 provided by the Regional Nurse #1 included staff will monitor and document the resident/patient's progress and responses to treatment. There was no additional information provided.	F 842		
F 880 SS=E	NJAC 8:39-35.2(d)6,16(e) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		11/17/23

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F 880	Continued From page 56 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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F 880	Continued From page 57 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and a review of pertinent facility documentation, it was determined that the facility failed to a). follow appropriate infection control practices for proper hand hygiene, b). ensure staff wore the appropriate personal protective equipment (PPE) for three residents who were on *Ex Order 26. 4B1* (Resident #19, #56 and #378) c).ensure communication that all *Ex Order 26. 4B1* residents were communicated from shift to shift accurately (Resident #99) and failed to d). ensure that multiuse medical equipment was properly disinfected on 2 of 4 nursing units ([redacted]-unit and the [redacted] floor *Ex Order 26. 4B1*).	F 880	Resident #19 The CNA was immediately in-service in r/t [redacted] Response Plan, strict contact/droplet precaution, appropriate PPE to use, and hand hygiene. Resident #56 The CNA was immediately in-service in r/t [redacted] Response Plan, strict contact/droplet precaution, appropriate PPE to use, and hand hygiene. Resident #99 The physician and Nurse Practitioner were notified immediately and	

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F 880	Continued From page 58 The deficient practice was evidenced by the following: 1. On 10/4/23 at 10:20 AM, during the entrance conference, the facility administration staff told the surveyor that all staff were required to wear full PPE prior to entering a COVID-19 (infectious disease cause by SARS-CoV-2 virus) room. Full PPE included wearing a N95 mask (respirator mask), goggles, gown and gloves. On 10/4/23 at 12:45 PM, during the initial tour on the [redacted]-unit, the surveyor interviewed a Licensed Practical Nurse (LPN#1) who told the surveyor that all Ex Order 26. 4B1 residents have signage outside their rooms identifying them as being on Ex Order 26. [redacted] precautions. On 10/4/23 at 1:00 PM, the surveyor observed Resident #56's door open. The resident was in bed watching television. Resident #56 had signage that indicated that the resident was under *Ex Order 26. 4B1* [redacted] precaution. The surveyor observed a PPE bin outside the resident's room. On 10/4/23 at 1:10 PM, the surveyor observed a Certified Nursing Assistant (CNA#1) who was wearing an N95 mask and goggles enter Resident #56's room without performing hand hygiene and without putting on a gown and gloves. The surveyor then observed CNA #1 exiting the resident's room carrying a meal tray which she placed inside a food truck. The CNA #1 did not perform hand hygiene after exiting the room. At that time, the surveyor interviewed CNA #1	F 880	*Ex Order 26. 4B1* [redacted] were discontinued. The Ex Order 26. 4B1 precaution was discontinued immediately. Resident #378 The Nurse was immediately in-serviced on *Ex Order 26. 4B1* [redacted], appropriate Ex Order 26 [redacted] to use, hand washing and disinfectant wipes to use for all Ex Order 26. [redacted] resident. Hand sanitizer was immediately removed from the room. The resident was maintained on contact precaution until the stool culture for *Ex Order 26. 4B1* [redacted] came back Ex Order 26. 4B1. This resident is currently on Ex Order 26. 4B1 [redacted] due to the history of *Ex Order 26. 4B1* [redacted]. *Ex Order 26. 4B1* [redacted] was consulted and evaluated. All the residents may be affected by this practice. " The Infection Preventionist and the Facility Educator will in-service all the employees on all matters related the proper infection control including but not limited to testing logs, isolation, new covid+ cases, proper PPE usage. " The Unit Managers will utilize the 24-hour report to communicate with the next shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 880	Continued From page 59 who acknowledged that Resident #56 had Ex Order 26. 4B1 and was on Ex Order 26. 4B1 precautions. The CNA#1 stated that before entering a Ex Order 26. 4B1 room, she had to perform hand hygiene, put on gloves and a gown and when exiting a room, she had to remove all PPE and then perform hand hygiene. The CNA#1 was unaware that she had to wear full PPE to remove a meal tray from a Ex Order 26. 4B1 room. The surveyor reviewed the medical record for Resident #56. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but was not limited to; Ex Order 26. 4B1 [redacted] A review of the Order Summary Report (OSR) included a physician's order (PO) dated Ex Order 26.4(b)(1), for 'Ex Order 26. 4B1 [redacted] " 2. On 10/4/23 at 1:30 PM, the surveyor observed CNA #2 enter a Ex Order 26. 4B1 room (Resident#19) without performing hand hygiene and putting on a gown, gloves or googles. The surveyor observed the CNA#2 open the door and exit the room exit the room. She then began to put on a pair of gloves. At that time, the surveyor interviewed CNA#2 who	F 880	" The Unit Managers will keep the COVID Testing Logbook in the unit. " The Infection Preventionist will check the COVID 19 test logbook daily. " The Nurses will utilize the new log test form for resident□s COVID testing and will be filed in the COVID test logbook. " The Infection Preventionist will send out a weekly updated isolation list to all the department heads via email and hard a copy report. " The Infection Preventionist and/or designee will be notified of a new or suspected communicable diseases or infections that can be transmitted to others. " The Facility Educator and Infection Preventionist will complete a PPE and hand hygiene competency for all the new employees as part of Infection Control training. " The Infection Preventionist and/or designee will audit 5 employees on appropriate use of PPE, hand hygiene, Transmission Base Precaution weekly than 10 employees monthly for 6 months. " The Infection Preventionist or designee will submit the audit report to the administrator at the Quality Assurance Improvement meeting which meets every 3 months.	

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F 880	Continued From page 60 stated that she entered Resident#19's room to wash her hands and then was going to put on PPE before performing care on the resident. The surveyor asked the CNA#2 if she was supposed to perform hand hygiene and put on the PPE before entering the room, she was unable to answer the surveyor's question. On 10/04/23 at 1:40 PM, the surveyor interviewed the Registered Nurse/Unit manager (RN#1/UM) who stated that the facility's policy was to perform hand hygiene and donning prior to entering a Ex Order 26. 4B1 room. She also stated that CNA#2 didn't need to go into the resident's room to wash her hands, they had hand sanitizer located outside the resident's room. She further stated that when the CNA#2 opened the resident's door that she should have perform hand hygiene since the doorknob was a high contact area. The surveyor reviewed the medical records for Resident #19. A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; *Ex Order 26. 4B1* [redacted]. A review of the OSR dated Ex.Order 26.4(b)(1), revealed a physician's order for "*Ex Order 26. 4B1* [redacted]" On 10/4/23 at 2:30 PM, the surveyor met with the facility administration team which included the Director of Nursing (DON),the Licensed Nursing Home Administrator (LNHA), and Regional Registered Nurse (RRN#1) and discussed the	F 880		

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F 880	Continued From page 61 above findings. No further information was provided. 3). On 10/5/23 at 10:00 AM, the surveyor observed Resident #99, self-propelling in their wheelchair toward the bathroom. The resident was alert and oriented but did not want to be interviewed. The surveyor observed the resident's room which had no stop sign or Ex Order 26. 4B1 signage on the door or wall, and no personal protection equipment (PPE) bin located outside of the resident's room. The surveyor reviewed the medical record for Resident # 99. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to Ex Order 26. 4B1 [redacted]. A review of Resident #99's progress notes (PN) revealed a nursing note dated Ex.Order 26.4(b)(1) at 3:30 PM which revealed the following documentation, Ex Order 26. 4B1, alert, Ex.Order 26.4(b)(1) noted, [redacted], Ex Order 26. 4B1 [redacted]. NP [nurse practitioner] visited new order noted, for Ex Order 26. 4B1 [twice a day] for 5 days, Ex Order 26. 4B1 x 6 days, Ex Order 26. 4B1	F 880		

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F 880	Continued From page 62 Ex Order 26. 4B1 x 7 days and Ex Order 26. 4B1 [three times a day] for 14 days, orders carried out." On 10/05/23 at 10:25 AM, the surveyor observed Resident #99's room in the presence of the Regional Registered Nurse #1 (RRN). The RRN #1 acknowledged that the resident had no stop sign or signage indicating that the resident was under Ex Order 26. 4B1 for Ex Order 26. 4B1, and that there was no PPE bin outside of the resident's room. The RRN#1 stated that the resident was Ex Order 26. 4B1 for Ex Order 26. 4B1 which was confirmed by the Registered Nurse/Unit Manager (RN#1/UM). On 10/05/23 at 10:30 AM, the surveyor interviewed the Unit Ex Order 26. 4B1 RN#1/UM, who stated that she got a report of all the residents who were Ex Order 26. 4B1 on her unit, and further stated that she had no confirmation that Resident #99 was Ex Order 26. 4B1 for Ex Order 26. 4B1. On 10/05/23 at 10:35 AM, the surveyor interviewed the Director of Nursing (DON) who was present on Unit Ex Order 26. 4B1. The DON stated that the resident was not Ex Order 26. 4B1. She stated that she had a list of all the residents who were Ex Order 26. 4B1 in the facility and Resident #99 was not on that list. At that same time, the surveyor reviewed Resident #99's Ex Order 26. 4B1 in the presence of the DON, RRN#1 and the RN/UM. After reviewing the resident's Ex Order 26. 4B1, the DON and RRN#1 stated that they would retest the resident and obtain a physician's order to put the resident on Ex Order 26. 4B1. On 10/05/23 at 10:45 AM, the surveyor observed	F 880		

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F 880	Continued From page 63 the result for the Ex Order 26. 4B1 Ex.Order 26.4(b)(1) for Resident #99 in the presence of the RN/UM. The rapid Ex Order 26. 4B1 test revealed that the resident was Ex Order 26. 4B1 for Ex Order 26. 4B1. On 10/05/23 at 12:43 PM, the surveyor interviewed the facility Ex Order 26. 4B1 who stated that she tested Resident #99 on Ex.Order 26.4(b)(1) and that the resident tested Ex Order 26. 4B1 for Ex Order 26. 4B1. The IP stated that the process for tracking resident Ex Order 26. 4B1 testing was to print out the midnight census and to write all the test results on the census sheet. All the residents who tested Ex Order 26. 4B1 had a check mark to the Ex Orde of their names while all the Ex Order 26. 4B1 residents had a Ex Order 26. 4B1. The IP showed the surveyor a copy of the 10/2/23 midnight census which showed a check mark to the Ex Orde of Resident #99's name. The IP stated she did not know how the Licensed Practical Nurse (LPN), or the Nurse Practitioner (NP) concluded that the resident was Ex Order 26. 4B1 . The IP provided a copy of the midnight census with the test result to the surveyor. At that time, the DON and RRN#1 who were present for the Ex Or interview acknowledge that their current Ex Order 26. 4B1 tracking log did not ensure proper tracking and communication of all Ex Order 26. 4B1 from shift to shift at the facility. They stated that they are in process of developing a new tracking log that would ensure proper communication from shift to shift. On 10/05/23 at 1:45 PM, the surveyor conducted a telephone interview with the NP in the presence of the survey team. The NP stated that she received a phone call from the LPN on Ex.Order 26.4(b)(1) and was told that Resident #99 tested Ex Order 26. 4B1 for Ex Order 26. 4B1. At that time, she gave a telephone	F 880		

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F 880	Continued From page 64	F 880		

order for four medications which included Ex Order 26. 4B1. The NP told the surveyor that Resident #99 had multiple Ex Order 26. 4B1 and that she wanted to start the resident on medications right away. The NP further stated that she saw the resident earlier in the day and that the resident tested Ex Order 26. 4B1. She stated that she discontinued all the medications and Ex Order 26. 4B1 precautions but since the resident had a Ex.Order 26.4(b)(1), she ordered a Ex Order 26. 4B1 to rule out any potential issues.

On 10/05/23 at 2:15 PM, the surveyor conducted a telephone interview with the Licensed Practical Nurse (LPN). The LPN stated that she came to work on Ex.Order 26.4(b)(1) and a staff member informed her that Resident #99 test Ex Order 26. 4B1 for Ex Order 26. 4B1. She was unable to speak to which staff member relayed that information. She also acknowledged that she did not see the resident's test results. She stated that there was a stop sign and signage for Ex Order 26. 4B1 and a Ex Order 26 bin outside of the resident's room. She further stated that the NP came to her unit on Ex.Order 26.4(b)(1, and asked her if any of her residents were Ex Order 26. 4B1 and she told the NP that Resident #99 was Ex Order 26. 4B1 and that the NP wrote new orders for the resident.

On 10/05/23 at 3:00 PM, the surveyor discussed the above findings with the facility administrative team which included the DON, Licensed Nursing Home Administrator, RRN#1, IP and the Assistant Director of Nursing.

On 10/10/23 at 10:00 AM, the surveyor in the prescence of the survey team met with the administrative staff. The DON confirmed and stated that they did not have an effective system

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F 880	Continued From page 65 in place to ensure that the facility was communicating a list of Ex Order 26. 4B1 residents from shift to shift. She acknowledged that this was what led to Resident # 99 being misdiagnosed as being Ex Order 26. 4B1 . 4. On 10/12/23 at 10:21 AM, while on the Ex.Order 26.4(b)(1) unit, the surveyors observed a stocked PPE caddy on the door and a "STOP Contact Ex Order 26. 4B1 " sign at the doorway of Resident #378's room. The sign read "Stop, Contact Precaution, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit....Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person." The surveyors then observed LPN #2 enter the room with the vital sign machine. LPN #2 was wearing an N95 mask and no other PPE. The surveyors observed LPN #2 place the Ex Order 26. 4 on the Ex Order 2 of Resident #378 and take the resident's Ex Order 26. 4B1 . On 10/12/23 at 10:22 AM, the surveyor brought the Licensed Practical Nurse/Unit Manger (LPN/UM) to the door of Resident #378 and asked what the "Stop Contact Precautions" signage meant. The LPN/UM stated that everything on the sign should be done before you enter the room. The LPN/UM stated that the resident was on contact Ex Order 26. 4B1 due to having Ex Order 26. 4B1 and that Ex Order 26. 4B1 was being ruled out." The LPN/UM observed LPN #2 in the room, cleaning the Ex Order 26. 4B1 with the purple top	F 880		

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F 880	Continued From page 66 wipes (Micro-Kill One, Germicidal Alcohol Wipes), wearing only an N95 mask. The LPN/UM stated that LPN #2 should have performed hand hygiene and then donned a gown and gloves before entering the room. The LPN/UM stated that the purpose of PPE was to "not transfer it ([redacted]) to self or others." On 10/12/23 at 10:25 AM, LPN #2 exited Resident #378's room. The surveyors asked what the "STOP Contact Precautions" sign meant, she stated that she "should wear gloves." She then stated that the "Contact sign was precautionary because the resident was a [redacted]." The surveyor asked if the sign should have been disregarded, LPN #2 stated, "no, I should have worn gloves and a gown" in the room. LPN#2 then showed the surveyor her shift report that had "[redacted] for [redacted]" written next to the resident's name. LPN #2 stated she was asked to clarify the order for "[redacted] for [redacted]". The LPN/UM told LPN #2 that Resident #378 was on [redacted] s because of [redacted] and that they (the facility) were ruling out [redacted]. On 10/12/23 at 10:36 AM, in the presence of the Infection Preventionist (IP), the LPN/UM and LPN #2, the surveyor asked if the purple top wipes were appropriate to kill [redacted]. The IP reviewed the purple top wipe container and confirmed that that they were not appropriate to kill [redacted]. The IP stated that the blue top "bleach wipes" (Micro-Kill Bleach, Germicidal Bleach Wipes) were needed to kill [redacted]. On 10/12/23 at 10:41 AM, during a follow up interview with the IP, the IP stated that contact precaution sign tells you exactly what to do before entering the room. She then stated the staff	F 880		

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F 880	Continued From page 67 should "read and follow the sign before you do anything." The surveyor reviewed the electronic medical record for Resident #378. A review of the Admission Record revealed the resident was admitted with diagnoses which included but not limited to: *Ex Order 26. 4B1* [redacted]. A review of the OSR revealed a PO: "Resident is on contact precautions for [redacted] every shift for [redacted] for 10 days" with a start date of [redacted]. A review of the Medication Administration Record (MAR) under "Resident is on contact precautions for [redacted] every shift for [redacted] for 10 days order date [redacted] 13:01" revealed that nursing had signed the MAR as completed for the "Eve" (evening) and "Nigh" (night) shifts for [redacted]. A review of the Care Plan (CP) revealed a "Focus: The resident is at risk for [redacted] r/t (related to) *Ex Order 26. 4B1*, Date Initiated [redacted]", and a "Goal: The resident will have no complications related to [redacted] through review date, Date Initiated: [redacted]." On 10/13/23 at 12:33 PM, during a meeting with the survey team, the surveyor made the LNHA, the DON, RRN #1 and RRN #2 aware of the above findings. RRN#1 stated that the "expectation of the staff was to follow the signs posted at the doors." A review of the Micro-Kill One, Germicidal Alcohol Wipes (purple top wipes) container did not list	F 880		

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F 880	Continued From page 68 that it was effective against *Ex Order 26. 4B1* [redacted]. A review of the Micro-Kill Bleach, Germicidal Bleach Wipes, (blue top wipes) container revealed that they were effective against the *Ex Order 26. 4B1* [redacted]. A review of the facility's "IN-SERVICE SIGN IN SHEET"; Topic: Precautions; Description: Nursing Identifying patients who are on *Ex Order 26. 4B1* [redacted] revealed that LPN #2 received an in-service on *Ex.Order 26.4(b)(1)* [redacted] A review of the facility's policy "Isolation-Categories of Transmission-Based Precautions" with a revised date of 1/2023, included the following: Policy Statement: 1. "...Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to other;" "Policy and Interpretation and Implementation: 1. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection." "Contact Precautions 1. In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident-care items in the resident's environment. 2. Examples of infections requiring Contact	F 880		

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F 880	Continued From page 69 Precautions include but are not limited to: b. Diarrhea associated with Clostridium difficile." "4. Gloves and Handwashing a. In addition to wearing gloves as outlined under standard precautions, wear gloves (clean, non-sterile) when entering the room. b. While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage). c. Remove gloves before leaving the room and perform hand hygiene. d. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room. 5. Gown a. Wear a disposable gown upon entering the contact precautions room or cubicle. b. After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces." "7. Resident-Care Equipment a. When possible, dedicate the use of non-critical resident-care equipment items such as stethoscope, sphygmomanometer, bedside commode, or electronic thermometer to a single resident (or cohort of residents) to avoid sharing between residents. b. If use of common items is unavoidable, then adequately clean and disinfect them before use of another resident. 8. Signs-the facility will implement a system to alert staff to the type of precaution resident requires: b. The facility utilizes the following system for identification of Contact Precautions	F 880		

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COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET HOLMDEL, NJ 07733**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 70 for staff and visitors: STOP and SEE NURSE." "Droplet Precautions 1. In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganism's transmitted by droplets (large-particle droplets ... that can be generated by the individual coughing, sneezing, talking or by the performance of procedures such as suctioning)." NJAC 8:39-5.1(a)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061342	A. BUILDING: _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey for 5 of the 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	a) Center staffing ratios as required by NJDOH were communicated to staffing coordinator and all Nurse managers and supervisors to match ratios of 1:8 on day shift; 1:10 on evening shift and 1:14 on night shift b) Center staffing schedule ratios are developed, reviewed and posted two weeks prior to utilization to comply with required staffing ratios. c) Administrator, DON and Staffing Coordinator meet every morning to go over daily staffing sheets and look ahead at copies of projected schedule of the next two weeks to ensure required staffing ratios. d) DON, Administrator and staffing	11/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/02/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061342	A. BUILDING: _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for weeks of 09/17/2023 to 09/30/2023. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -09/17/23 had 11 CNAs for 119 residents on the day shift, required at least 15 CNAs. -09/18/23 had 5 CNAs for 119 residents on the day shift, required at least 15 CNAs. -09/23/23 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. -09/24/23 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. -09/25/23 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. On 10/16/23 at 11:38 AM, the surveyor	S 560	coordinator meet weekly to review the 4 week master schedule to ensure facility has staff that meets the needs. All residents have potential to be affected by the same deficit practice. If staffing deficits on master staffing schedule are identified, Center will communicate all unfilled shifts to in-house staff for coverage. Center will continue external recruitment efforts to fill open positions and review and revise as necessary Center will maintain multiple contacts with staffing agencies to meet required staffing ratios and review as necessary Center will continue to offer bonus structure to incentivize staff to fill shifts if needed and revise as necessary. Center will continue to make efforts to retain staff by way of employee engagement events. Center Staffing Coordinator will review projected census and staffing ratio to assure staffing compliance. Administrator, DON, and Staffing Coordinator will continue to meet daily to go over projected staffing to assure required staff ratios. If ratios are projected to not be met, Center will post openings for in-house staff as well as contact contracted agencies to maintain staffing compliance. DON/Staffing Coordinator will conduct daily staffing audits for two weeks and bi-weekly for two months. Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061342	A. BUILDING: _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 interviewed the Staffing Coordinator (SC) regarding the CNA staffing. The SC stated that she was aware of the staffing ratios and that she was trying to meet the staffing ratios. She identified Sundays as being the most difficult day to staff. A review of the facility's policy "Staffing", revised January 2023, revealed under Policy Statement: Our facility provides adequate staffing to meet needed care and services for our resident population; Policy Interpretation and Implementation: 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met; 2.Certified Nursing Assistants are available on each shift to provide the needed care and services each resident as outlined on the resident's comprehensive care plan.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315252 Y1	A. Building B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0657	Correction	ID Prefix F0658	Correction	ID Prefix F0694	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(h)	Completed
LSC	11/17/2023	LSC	11/17/2023	LSC	11/03/2023
ID Prefix F0695	Correction	ID Prefix F0698	Correction	ID Prefix F0755	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	11/17/2023	LSC	11/17/2023	LSC	11/17/2023
ID Prefix F0757	Correction	ID Prefix F0761	Correction	ID Prefix F0842	Correction
Reg. # 483.45(d)(1)-(6)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed
LSC	11/17/2023	LSC	11/17/2023	LSC	11/17/2023
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	11/17/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/19/2023	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315252 Y1	A. Building B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658	Correction	ID Prefix F0755	Correction	ID Prefix F0842	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed
LSC	11/17/2023	LSC	11/17/2023	LSC	11/17/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/19/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061342 Y1	A. Building B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/17/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061342 Y1	A. Building B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/17/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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	

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET** **HOLMDEL, NJ 07733**

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E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 10/10/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/10/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Complete Care at Bayshore is a two-story building that was built in 1988. It is composed of Type II protected construction. The facility is divided into 13 - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 129 of 232. .	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings	K 311		11/1/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/01/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 311	Continued From page 1 between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure fire rated door assemblies for stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect 129 residents. Findings include: An observation on 10/10/23 at 2:13 PM revealed one of ten stairway exit doors, located on the second floor adjacent to the activity room, was equipped with panic hardware which violated the listing of the rated fire door assembly. During an interview at the time of observation, the Maintenance Director and Administrator confirmed the stairway exit door was equipped with panic hardware. NJAC 8:39-31.2(e) NFPA 80 .	K 311	1. The fire door hardware identified near the stairway exit door, located on the second floor adjacent to the activity room was replaced with the correct fire-rated door assemblies with approved fire exit hardware. 2. All residents have the potential to be affected by this deficient practice. The remainder of the facility fire doors were assessed to ensure proper hardware was in place with no further non-compliance noted. 3. The Maintenance Director was educated on correct fire-rated door assemblies with approved fire exit hardware to ensure any further corrections to facility fire doors receive proper hardware. 4. The administrator or designee will audit all facility fire doors to ensure the correct fire-rated door assemblies with approved fire exit hardware are in place weekly for four weeks, then monthly for two months. All findings will be reported to the administrator at the facility's monthly QAPI meeting.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		11/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 372	Continued From page 2 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: . Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) Section 8.5.2.2. This deficient practice had the potential to affect 129 residents. Findings include: An observation on 10/10/23 at 3:20 PM revealed the smoke barrier, located in B-wing above the smoke barrier doors adjacent to the office, had a one-inch by one-inch hole with one low voltage wire going through it and was not protected by a system or material capable of restricting the transfer of smoke. An observation on 10/10/23 at 3:24 PM revealed the smoke barrier, located in B-wing above the smoke barrier doors adjacent to the dining room,	K 372	1. The smoke barrier penetrations located in B-wing above the smoke barrier doors adjacent to the office, dining room, and resident room 110 were sealed with material capable of restricting the transfer of smoke. 2. All residents have the potential to be affected by this practice. The remainder of the facility's smoke barrier doors were audited for any further penetrations. No further non-compliance was noted. 3. The Maintenance Director was educated on the importance of ensuring penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke. The Maintenance Director will conduct a full check of any work completed in the facility by an outside vendor to ensure no penetrations are left and the facility remains in compliance. 4. The Maintenance Director or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET** **HOLMDEL, NJ 07733**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 3 had a one-inch by one-inch hole with one low voltage wire going through it and was not protected by a system or material capable of restricting the transfer of smoke. An observation on 10/10/23 at 3:28 PM revealed the smoke barrier, located in B-wing above the smoke barrier doors adjacent to room 110, had a one-inch by one-inch hole with five high voltage wire going through it and was not protected by a system or material capable of restricting the transfer of smoke. During an interview at the time of the observations, the Maintenance Director and the Administrator confirmed the penetrations in the smoke barriers were not protected by a system or material capable of restricting the transfer of smoke. NJAC 8:39-31.1(c). 31.2(e) .	K 372	designee will complete a random audit of all smoke barrier doors to ensure penetration barriers remain intact monthly times 3 months and then quarterly for three months. All findings will be reported at the facility's administrator monthly QAPI meeting.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For	K 914		11/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315252	A. BUILDING **01** B. WING _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	**715 NORTH BEERS STREET** **HOLMDEL, NJ 07733**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 4 LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to ensure electrical outlet testing was conducted annually on the electrical system in accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3. This deficient practice had the potential to affect 129 residents. Findings include: Document review of the Fire Safety Folder for 2023, provided by the Maintenance Director, revealed the electrical outlet testing was not completed on the electrical outlets. During an interview at 3:55 PM on 10/10/23, the Administrator confirmed that the electrical outlet testing was not completed on the electrical system. . .	K 914	1. The facility completed the facility electrical outlet testing and ensured proper documentation was in place. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was educated on the importance of completing the facility's electrical system testing. The maintenance department or designee will implement a work order into the facility maintenance calendar to ensure all electrical outlets are inspected yearly. 4. The Maintenance Director or designee will randomly audit the maintenance work order schedule to ensure no further regulatory tasks are missed and are completed timely. This audit will be completed monthly for 3 months, then quarterly for 6 months. All findings will be reported to the administrator at the facility's monthly QAPI meeting.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315252 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BAYSHORE LLC	715 NORTH BEERS STREET HOLMDEL, NJ 07733

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	11/01/2023	LSC K0372	11/01/2023	LSC K0914	11/01/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/19/2023	☐ YES ☐ NO