

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20C100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2025
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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VICTORIA COMMONS, L	STREET ADDRESS, CITY, STATE, ZIP CODE 610 TOWNBANK ROAD NORTH CAPE MAY, NJ 08204
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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) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: Complaint#: NJ00181056 and NJ00182119 and Revisit</p> <p>Survey Dates: 12/11/24 and 1/31/25</p> <p>Census: 61</p> <p>Sample: 8</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

03/31/25

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint: #NJ00181056</p> <p>Based on interview and review of records, it was determined that the facility failed to ensure the development, implementation, and enforcement of all policies and procedures including "Administering Medications" and "Resident Rights." The facility Director of Nursing/Registered Nurse failed to ensure a Certified Nursing Assistant was not allowed to administer medications without a proper certification to 3 of 8 facility residents reviewed, Resident#'s 2, 3, and 4. This deficient practice was evidenced by the following:</p> <p>On 12/10/24 at 11:40 a.m., the surveyor interviewed a facility Licensed Practical Nurse, (LPN #1), who stated that when she came to work on the morning of [REDACTED] she was told by a co-worker that a facility CNA had passed medications on the prior evening shift, due to two nursing call outs. LPN #1 additionally stated that she called and notified the facility Administrator right away, and that the Administrator became aware.</p> <p>1. On 12/10/24, the surveyor reviewed Resident #2's Medical Record (MR) which revealed [REDACTED]</p> <p>On 12/10/24 at 11:55 a.m., the surveyor</p>	A 310		
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A 310	<p>Continued From page 2</p> <p>interviewed a facility resident, Resident #2 who stated that the CNA administered his/her medications that were due at 4:00 p.m. on "that day" and remembered it well, because he/she ^{NJ Ex Order 26.4(b)(1)} the CNA. Resident #2 stated that it was the only time the CNA ever administered medications to him/her, and that he was just doing what he was told to do. Resident #2 further stated that the Director of Nursing (DON) was standing right there, and that she watched the CNA give the medications to Resident #2.</p> <p>At 12:14 p.m., the surveyor interviewed a facility LPN (LPN #2), who stated that on the date of ^{NJ Ex Order 26.4(b)(1)}, there were two nurses scheduled to work the 3:00 p.m. -11:00 p.m., shift. One of the nurses did not show up, and the other was an agency nurse who canceled her shift. LPN #2 stated that she notified the DON that the same two nurses were scheduled to work the following evening, which was ^{NJ Ex Order 26.4(b)(1)}, and that there was a concern for coverage. LPN #2 additionally stated that the DON indicated that she would work on the staffing; however, when the following evening came, no nursing coverage was found for the 3:00 p.m. -11:00 p.m. shift on 10/18/24.</p> <p>During continued surveyor interview, LPN #2 stated that LPN #3, who was an agency nurse, had worked the 7:00 a.m.-3:00 p.m. shift, and ended up staying until between 5:30 p.m. and 6:00 p.m.; however, an additional nurse was required for the second medication cart.</p> <p>On 12/10/24 at 3:20 p.m., the surveyor interviewed the facility CNA who stated that the DON asked him if he would help administer medications that evening since she could not find additional nursing coverage. The CNA further</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>stated that the DON told him that since he had taken the Certified Medication Aide (CMA) class, it would be good practice for him. The CNA stated that he passed medications to four or five residents, but was only able to recall the names of three residents, Resident #2, Resident #3 and Resident #4.</p> <p>When the surveyor asked the CNA whether he NJ Ex Order 26. 4B1 to Resident #2, he stated yes, and that was something he learned in CMA class. When the surveyor inquired about how he checked the NJ Ex Order 26. 4B1 or knew how much NJ Ex Order 26. 4B1 to give, he stated that Resident #2 had an "app" on his/ her phone that read the NJ Ex Order 26. 4B1, and that LPN #3, helped to determine the correct NJ Ex Order 26. 4B1 dose for the CNA to administer.</p> <p>The CNA stated that although he taken the CMA course, he had not yet been scheduled to take the exam, nor had he been trained to pass medications in the facility. When the surveyor inquired as to why he agreed to pass medications, he stated that sometimes when he feels nervous, he "tends to freeze up"; and, additionally that he wanted to follow the direction given to him by the DON. The CNA stated that LPN #3, showed him how to "work" the computer Electronic Medication System (EMR) to give the medications, and also gave him a quick overview of the medication cart. The CNA additionally stated that the DON was present with the CNA at that time, but then left after about a half hour.</p> <p>During continued interview, when the surveyor asked the CNA how he signed for the medications that he administered, he stated that LPN #3 logged him in, under her name.</p> <p>The CNA further stated that a facility Certified</p>	A 310		

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A 310	<p>Continued From page 4</p> <p>Medication Aide (CMA), arrived to assist with medication pass that evening at approximately 5:30 p.m. or 5:45 p.m., which was when he stopped passing medications.</p> <p>2. On 12/11/24, the surveyor reviewed Resident #3's MR which revealed NJ Ex Order 26. 4B1 [REDACTED].</p> <p>On 12/11/24 at 10:55 a.m., during surveyor interview with Resident #3 he/she stated that the CNA administered his/her medications on one evening NJ Ex Order 26.4(b)(1) and that he/she was shocked, but also grateful to receive his/her medications. Resident #3 stated that usually in the evening, the nurse brought the medication to his/her apartment; however, when the nurse didn't come, Resident #3 went to the wellness office which was when the CNA administered the medications to him/her. Resident #3 further stated that evening was the only time he/she ever received medications from a CNA.</p> <p>3. The surveyor reviewed Resident #4's MR which revealed NJ Ex Order 26. 4B1 [REDACTED]. Resident #4 was not available for interview.</p> <p>On 12/11/24, at 11:49 a.m., the surveyor interviewed the DON who stated that the CNA should not have been passing medications that evening. The DON additionally stated that she told the CNA to help out however he could, but did not specifically tell him to pass medications. The DON further stated that she was unaware that the CNA had passed medications to residents, until the Ombudsman visited and told her.</p>	A 310		

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A 310	<p>Continued From page 5</p> <p>When the surveyor asked the DON whether she investigated or completed an incident report, she stated that she had not. The DON further stated, "why would I do that if I'm the one being investigated?" The DON further stated that the Administrator should have done the investigation. The surveyor asked the DON if she knew which residents the CNA passed medications to, and she stated that she had no idea.</p> <p>When the surveyor asked the DON why she did not stay to pass medications on the evening of NJ Ex Order 26.4(0), when she was unable to find proper nursing coverage, she stated that she had an emergency. When the surveyor asked if there was another Registered Nurse (RN) available when she was unavailable, on vacation, or when there were staffing issues, the DON stated that she was the only RN on staff.</p> <p>Agency LPN #3's phone number was provided to the surveyor by the facility, however, LPN #3 did not answer the phone on the dates of 12/11/24, 12/12/24 and 12/17/24.</p> <p>On 12/17/24 at 10:45 a.m., during surveyor interview with the facility Administrator (ED), she stated that she was not notified that the CNA had passed medications until the Monday after that weekend, but that she could not recall who told her.</p> <p>The ED additionally stated that from what she could remember, the DON found out about the CNA passing medications on that Monday as well. The ED stated that a formal investigation was not done, however when she looked into it and asked the CNA whether he administered medications to the residents, he stated that he</p>	A 310		
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A 310	<p>Continued From page 6</p> <p>didn't. The ED stated that she spoke to LPN #3 who also denied that the CNA administered medications. The ED stated that based on what the CNA and LPN #3 said, she didn't investigate further. The ED further stated that when the Ombudsman visited, she thought they were just visiting to follow up on staffing.</p> <p>The surveyor reviewed a facility policy titled, "Administering Medications" with an updated date of 10/2022 which indicated the following: "1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so...."</p> <p>The surveyor reviewed an undated facility policy titled, "Resident Rights" that indicated the following: "...In accordance with the State of New Jersey Assisted Living Regulations, resident rights are reviewed during the admission process to the facility. The residents are then given their own copy of the resident rights. A copy of the Resident Rights is available to any family member that requests it. Resident Rights are given to each resident annually. Resident Rights are reviewed with staff during orientation and reviewed annually."</p> <p>The surveyor did not observe any additional information within the facility policy titled, "Resident Rights" that included the list of Resident Rights.</p> <p>On 1/31/25, a Revisit survey was conducted and found that the facility's Removal Plan (RP) submitted to the Department of Health, was not implemented to include the following (per their RP); in-services on medication administration and documentation to all LPNs and CMAs, as well as</p>	A 310		

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A 310	Continued From page 7 in-services to all CNAs to work within the scope of their certification and job descriptions. Additionally, the Revisit survey confirmed that the facility failed to develop policies and procedures that ensured incidents and its investigations were addressed.	A 310		
A 312	8:36-3.4(a)(3) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 3. Ensuring that all personnel are assigned duties based upon their ability and competency to perform the job and in accordance with written job descriptions; This REQUIREMENT is not met as evidenced by: Complaint: #NJ00181056 Based on observation, interview and review of records, it was determined that the facility failed to ensure a Certified Nurses Aide (CNA), a staff with no license/certified and not authorized to perform medication administration, did not administer medications to 3 of 8 residents reviewed, Resident #'s 2, 3, and 4. This deficient practice was evidenced by the following: Based on observation, interview and review of records, it was determined that the facility failed to ensure that all personnel were assigned duties based upon their ability and competency to perform the job and in accordance with written job descriptions. The facility Director of Nursing (DON)/Registered Nurse (RN) did not ensure that	A 312		

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A 312	<p>Continued From page 8</p> <p>a Certified Nursing Assistant (CNA) who is not authorized to administer did not administer medications to 3 of 8 facility residents reviewed, Resident#s 2, 3, and 4.</p> <p>On 12/10/24 at 11:40 a.m., the surveyor interviewed a facility Licensed Practical Nurse, (LPN #1) who stated that when she came to work on the morning of [redacted], and was told by a co-worker that a facility CNA had passed medications on the prior evening shift because there were two call outs. LPN #1 stated that she called and notified the facility Administrator right away, and that the Administrator was aware that morning.</p> <p>1. On 12/10/24, the surveyor reviewed Resident #2's Medical Record (MR) which revealed [redacted].</p> <p>On 12/10/24 at 11:55 a.m., the surveyor interviewed a facility resident, Resident #2 who stated that the CNA administered his/her medications that were due at 4:00 p.m. on "that day" and that he/she remembered it well because he/she [redacted] the CNA. Resident #2 stated that it was the only time the CNA ever administered medications to him/her and that he was just doing what he was told to do. Resident #2 further stated that the Director of Nursing (DON) was standing right there, and that she watched the CNA give the medications to Resident #2.</p> <p>At 12:14 p.m., the surveyor interviewed a facility LPN #2, who stated that on the date of [redacted], there were two nurses scheduled to work the 3:00 p.m.-11:00 p.m., shift. One of the nurses did not</p>	A 312		

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A 312	<p>Continued From page 9</p> <p>show up, and the other was an agency nurse who cancelled her shift. LPN #2 stated that she notified the DON that the same two nurses were scheduled to work the following evening, which was a Friday NJ Ex Order 26, 4B1, and that there was a concern for coverage. Additionally, LPN #2 stated that the DON indicated that she would work on the staffing; however, when the following evening came, no nursing coverage was found for the 3:00 p.m. -11:00 p.m. shift.</p> <p>During continued surveyor interview, LPN #2 stated that LPN #3, who was an agency nurse, had worked the 7:00 a.m.-3:00 p.m. shift, and ended up staying until between 5:30 p.m. and 6:00 p.m. that evening; however, an additional nurse was required for the second medication cart.</p> <p>On 12/10/24 at 3:20 p.m., the surveyor interviewed the facility CNA who stated that the DON asked him if he would help administer medications that evening since she could not find additional nursing coverage. The CNA further stated that the DON told him that since he had taken the Certified Medication Aide (CMA) class, it would be good practice for him. The CNA stated that he passed medications to four or five residents, but was only able to recall the names of three residents, Resident #2, Resident #3 and Resident #4.</p> <p>When the surveyor asked the CNA whether he NJ Ex Order 26, 4B1 to Resident #2, he stated that he did, and that was something he learned in CMA class. When the surveyor inquired about how he checked the NJ Ex Order 26, 4B1 or knew how much NJ Ex Order 26, 4B1 to give, he stated that Resident #2 had an "app" on his/ her phone that read the NJ Ex Order 26, 4B1, and that LPN #3, helped to</p>	A 312		

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A 312	<p>Continued From page 10</p> <p>determine the correct ^{NJ Ex Order 26} [REDACTED] dose for the CNA to ^{NJ Ex Order 26, 4B1} [REDACTED]</p> <p>The CNA stated that although he taken the CMA course, he had not yet been scheduled to take the exam, nor had he been trained to pass medications in the facility. When the surveyor inquired as to why he agreed to pass medications, he stated that sometimes when he feels nervous, he "tends to freeze up"; and, additionally that he wanted to follow the direction given to him by the DON. The CNA stated that LPN #3, showed him how to "work" the computer Electronic Medication System (EMR) to give the medications, and also gave him a quick overview of the medication cart. The CNA additionally stated that the DON was present with the CNA at that time, but then left after about a half hour.</p> <p>During continued interview, when the surveyor asked the CNA how he signed for the medications that he administered, he stated that LPN #3 logged him in under her name.</p> <p>The CNA further stated that a facility Certified Medication Aide (CMA) arrived to assist with medication pass that evening at approximately 5:30 p.m. or 5:45 p.m., which was when he stopped passing medications.</p> <p>2. On 12/11/24 the surveyor reviewed Resident #3's MR which revealed ^{NJ Ex Order 26, 4B1} [REDACTED].</p> <p>On 12/11/24 at 10:55 a.m., during surveyor interview with Resident #3 he/she stated that the CNA administered his/her medications on one evening ^{NJ Ex Order 26.4(b)(1)} [REDACTED] and that he/she was shocked, but also grateful that to receive his/her</p>	A 312		
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A 312	<p>Continued From page 11</p> <p>medications. Resident #3 stated that usually in the evening, the nurse brought the medication to his/her apartment, however when the nurse didn't come, Resident #3 went to the wellness office which was when the CNA gave the medications to him/her. Resident #3 further stated that evening was the only time he/she ever received medications from a CNA.</p> <p>3. The surveyor reviewed the Resident #4's MR which revealed NJ Ex Order 26. 4B1 [REDACTED]. Resident #4 was not available for interview.</p> <p>On 12/11/24, at 11:49 a.m., the surveyor interviewed the DON who stated that the CNA should not have been passing medications that evening. The DON additionally stated that she told the CNA to help out however he could, but did not specifically tell him to pass medications. The DON further stated that she was unaware that the CNA had passed medications to residents, until the Ombudsman came in and told her.</p> <p>When the surveyor asked the DON whether she investigated or completed an incident report, she stated that she had not. The DON further stated, "why would I do that if I'm the one being investigated?" The DON further stated that the Administrator should have done the investigation. The surveyor asked the DON if she knew which residents the CNA passed medications to, and she stated that she had no idea.</p> <p>When the surveyor asked the DON why she did not stay to pass medications on the evening of NJ Ex Order 26.4(0)(1) [REDACTED] when she could not find proper nursing coverage, she stated that she had an emergency.</p>	A 312		
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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VICTORIA COMMONS, LI	STREET ADDRESS, CITY, STATE, ZIP CODE 610 TOWNBANK ROAD NORTH CAPE MAY, NJ 08204
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A 312	<p>Continued From page 12</p> <p>When the surveyor asked if there was another Registered Nurse (RN) available when she was unavailable, on vacation, or when there were staffing issues, the DON stated that she was the only Registered Nurse on staff.</p> <p>Agency LPN #3 's phone number was provided by facility, however she did not answer the phone on the dates of 12/11/24, 12/12/24 and 12/17/24.</p> <p>On 12/17/24 at 10:45 a.m., during surveyor interview with the facility Administrator (ED), she stated that she was not notified that the CNA was passing medications until the Monday after that weekend on [REDACTED], but that she could not recall who told her.</p> <p>The ED additionally stated that from what she could remember, the DON found out about the CNA passing medications on that Monday as well. The ED stated that a formal investigation was not done, however when she looked into it and asked the CNA whether he administered medications to the residents, he stated that he didn't. The ED stated that she spoke to LPN #3 who also denied that the CNA administered medications. The ED stated that based on what the CNA and LPN said, she didn't investigate further.</p> <p>On 1/31/25, the surveyor conducted a Revisit survey and confirmed that the Removal Plan was not implemented to include the following; in-services on medication administration and documentation to all LPNs and CMAs, as well as in-services to all CNAs on working within the scope of their certification and job description. Additionally, the Revisit survey revealed that there was no Policy and Procedure developed addressing facility's incidents and investigations.</p>	A 312		

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A 401	<p>8:36-4.1(a)(22) Resident Rights</p> <p>(a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights:</p> <p>22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint: #NJ00181056</p> <p>Based on interview and review of records, it was determined the facility failed to ensure that the resident right to live in a safe environment by allowing a Certified Nursing Assistant to administer medications without a proper license, to 3 of 8 residents reviewed, Resident #'s 2, 3 and 4.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 12/10/24 at 11:40 a.m., the surveyor interviewed a facility Licensed Practical Nurse, (LPN #1) who stated that when she came to work on the morning of [REDACTED], she was told by a co-worker that a facility CNA had passed medications on the prior evening shift because there were two call outs. LPN #1 additionally stated that she called and notified the facility</p>	A 401		

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A 401	<p>Continued From page 14</p> <p>Administrator right away, and that the Administrator was aware that morning.</p> <p>1. On 12/10/24, the surveyor reviewed Resident #2's Medical Record (MR) which revealed [REDACTED].</p> <p>On 12/10/24 at 11:55 a.m., the surveyor interviewed a facility resident, Resident #2 who stated that the CNA administered his/her medications that were due at 4:00 p.m. on "that day" and that he/she remembered it well, because he/she [REDACTED] for the CNA. Resident #2 stated that it was the only time the CNA ever administered medications to him/her and that he was just doing what he was told to do. Resident #2 further stated that the Director of Nursing (DON) was standing right there, and that she watched the CNA give the medications to Resident #2.</p> <p>At 12:14 p.m., the surveyor interviewed a facility LPN #2, who stated that on the date of [REDACTED], there were two nurses scheduled to work the 3:00 p.m. -11:00 p.m., shift. One of the nurses did not show up, and the other was an agency nurse who cancelled her shift. LPN #2 stated that she notified the DON that the same two nurses were scheduled to work the following evening, which was a Friday [REDACTED], and that there was a concern for coverage. LPN #2 additionally stated that the DON indicated that she would work on the staffing; however, when the following evening came, no nursing coverage was found for the 3:00 p.m. -11:00 p.m. shift.</p> <p>During continued surveyor interview, LPN #2 stated that LPN #3 who was an agency nurse,</p>	A 401		
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A 401	<p>Continued From page 15</p> <p>had worked the 7:00 a.m.-3:00 p.m. shift, and ended up staying until between 5:30 p.m. and 6:00 p.m. that evening; however, an additional nurse was required for the second medication cart.</p> <p>On 12/10/24 at 3:20 p.m., the surveyor interviewed the facility CNA who stated that the DON asked him if he would help administer medications that evening since she could not find additional nursing coverage. The CNA further stated that the DON told him that since he had taken the Certified Medication Aide (CMA) class, it would be good practice for him. The CNA stated that he passed medications to four or five residents but was only able to recall the names of three residents, Resident #2, Resident #3 and Resident #4.</p> <p>When the surveyor asked the CNA whether he NJ Ex Order 26. 4B1 to Resident #2, he stated that he did, and that was something he learned in CMA class. When the surveyor inquired about how he checked the NJ Ex Order 26. 4B1 or knew how much NJ Ex Order 26. 4B1 to give, he stated that Resident #2 had an "app" on his/ her phone that read the NJ Ex Order 26. 4B1, and that LPN #3, helped to determine the correct NJ Ex Order 26. 4B1 dose for the CNA to administer.</p> <p>The CNA stated that although he taken the CMA course, he had not yet been scheduled to take the exam, nor had he been trained to pass medications in the facility. When the surveyor inquired as to why he agreed to pass medications, he stated that sometimes when he feels nervous, he "tends to freeze up"; and additionally that he wanted to follow the direction given to him by the DON. The CNA stated that LPN #3, showed him how to "work" the computer</p>	A 401		

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A 401	<p>Continued From page 16</p> <p>Electronic Medication System (EMR) to give the medications, and also gave him a quick overview of the medication cart. The CNA additionally stated that the DON was present with the CNA at that time, but then left after about a half hour.</p> <p>During continued interview, when the surveyor asked the CNA how he signed for the medications that he administered, he stated that LPN #3 logged him in under her name.</p> <p>The CNA further stated that a facility Certified Medication Aide (CMA) arrived to assist with medication pass that evening at approximately 5:30 p.m. or 5:45 p.m., which was when he stopped passing medications.</p> <p>2. On 12/11/24 the surveyor reviewed Resident #3's MR which revealed NJ Ex Order 26. 4B1 [REDACTED].</p> <p>On 12/11/24 at 10:55 a.m., during surveyor interview with Resident #3 he/she stated that the CNA administered his/her medications on one evening NJ Ex Order 26.4(b)(1) and that he/she was NJ Ex Order 26.4(b) but also grateful that to receive his/her medications. Resident #3 stated that usually in the evening, the nurse brought the medication to his/her apartment however when the nurse didn't come, Resident #3 went to the wellness office which was when the CNA gave the medications to him/her. Resident #3 further stated that evening was the only time he/she ever received medications from a CNA.</p> <p>3. The surveyor reviewed Resident #4's MR which revealed a NJ Ex Order 26. 4B1 [REDACTED]. Resident #4 was not</p>	A 401		

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A 401	<p>Continued From page 17</p> <p>available for interview.</p> <p>On 12/11/24, at 11:41 a.m., the surveyor interviewed the DON who stated that the CNA should not have been passing medications that evening. The DON additionally stated that she told the CNA to help out however he could but did not specifically tell him to pass medications. The DON further stated that she was unaware that the CNA had passed medications to residents, until the Ombudsman came in and told her.</p> <p>When the surveyor asked the DON whether she investigated or completed an incident report, she stated that she had not. The DON additionally stated, "why would I do that if I'm the one being investigated?" The DON stated that the Administrator should have done the investigation. The surveyor asked the DON if she knew who were the residents that received medications from the CNA. The DON stated that she "had no idea."</p> <p>When the surveyor asked the DON why she did not stay to pass medications on the evening of NJ Ex Order 26.4(b), when she could not find proper nursing coverage, she stated that she had an emergency. When the surveyor asked if there was another Registered Nurse (RN) available when she was unavailable, on vacation, or when there were staffing issues, the DON stated that she was the only Registered Nurse on staff.</p> <p>The surveyor reviewed an undated facility policy titled, "Resident Rights", which indicated the following..."In accordance with the State of New Jersey Assisted Living Regulations, resident rights are reviewed during the admission process to the facility. The residents are then given their own copy of the resident rights. A copy of the</p>	A 401		

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A 401	<p>Continued From page 18</p> <p>Resident Rights is available to any family member that requests it. Resident Rights are given to each resident annually. Resident Rights are reviewed with staff during orientation and reviewed annually."</p> <p>The surveyor did not observe any additional information within the facility policy titled, "Resident Rights", that included the list of Resident Rights.</p> <p>On 12/17/24 at 10:45 a.m., during a follow up phone interview with the facility Administrator (ED), she stated to the surveyor that she was not notified that the CNA was passing medications until the Monday after that weekend, NJ Ex Order 26.4(b)(1), but that she could not recall who told her.</p> <p>The ED additionally stated that from what she could remember, the DON found out about the CNA passing medications on that Monday as well. The ED stated that a formal investigation was not done, however when she looked into it and asked the CNA whether he administered medications to the residents, he stated that he didn't. The ED stated that she spoke to LPN #3 who also denied that the CNA administered medications. The ED stated based, on what the CNA and LPN #3 said, she didn't investigate further.</p> <p>On 1/31/25, a Revisit survey was conducted and determined that the Removal Plan submitted to the NJ DOH, was not implemented to include the following areas: in-services on medication administration and documentation to all LPNs and CMAs, as well as in-services to all CNAs to work within the scope of their certification and job descriptions. Additionally, the Revisit survey revealed that policies and procedures regarding</p>	A 401		

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A 401	Continued From page 19 incidents and investigations were not developed; there was no documented evidence provided during the revisit survey.	A 401		
A 515	<p>8:36-5.6(a) General Requirements</p> <p>(a) The facility or program shall maintain and implement written staffing schedules. Actual hours worked by each employee shall be documented.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ0018219</p> <p>Based on interview and review of records, it was determined that the facility Administrator failed to ensure that facility's written staffing schedule accurately documented the actual hours worked by each employee in the facility. This deficient practice was evidenced by the following:</p> <p>On 1/31/25 at 10:13 a.m., during the entrance conference, the surveyor requested the staffing schedule from weeks of 12/22/24 to present/time of survey that reflected the actual hours worked, as well as staff members who had certification on cardiopulmonary resuscitation on each shift from the Administrator.</p> <p>At 11:13 a.m., when the surveyor asked about staffing based on acuities, the Administrator stated that the staffing was not based on acuities and the facility only had residents with NJ Ex Order <i>NJ Ex Order 26. 4B1</i></p> <p>At 12:35 p.m., the surveyor requested the staffing sheets a second time, the Administrator replied</p>	A 515		

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A 515	<p>Continued From page 20</p> <p>that the Director of Nursing (DON) does the staff list and there was a monthly master spreadsheet, but this did not show the hours worked. The Administrator continued to say that the assignment sheets were used for the staffing schedule to show the staff who were in the building, who actually worked on that shift.</p> <p>In the same interview, the Administrator stated that the facility does not have an acuity based Staffing Policy.</p> <p>At 2:25 p.m., the Administrator provided the staffing schedule from 12/22/24 to present, but it did not reveal the actual hours worked and the CPR certified staff on each shift. When the surveyor asked her about it, she stated that she contacted the DON for it because she did not have access to it.</p> <p>At 3:05 p.m., the Administrator stated she did not get a response yet from the DON.</p> <p>On 2/3/25 at 12:49 p.m, during a telephone interview, the DON stated that there was no spreadsheet showing CPR certified staff and actual hours worked [by staff], she only used the assesement sheets showing what staff acutally worked. She continued to say that the assessment sheets were the assignment sheets.</p> <p>At the time of the survey, the Administrator was unable to provide the staffing weeks requested showing the actual hours worked and the CPR certified staff on each shift.</p>	A 515		
A 539	<p>8:36-5.7(a)(2) General Requirements</p> <p>(a) A policy and procedure manual(s) for the</p>	A 539		

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A 539	<p>Continued From page 21</p> <p>organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following:</p> <p>2. A description of the services which the assisted living residence, comprehensive personal care home or assisted living program is capable of providing;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint: #NJ00181056</p> <p>Based on observation, interview and review of records, it was determined that the facility failed to provide documentation of a policy that included a description of services that the assisting living was capable of providing. This was evidenced by the following:</p> <p>On 12/10/2024 at 11:10 a.m., during interview with the facility Administator (ED), the surveyor asked where the facility policies and procedures were located and the ED stated that all of the facility policies were electronic and that she believed they were located within the Electronic Medical Record system (EMR). The surveyor requested access to the facility EMR at that time and initially requested several policies including a policy regarding staffing levels for acuity and policy on staff orientation.</p>	A 539		

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A 539	<p>Continued From page 22</p> <p>On 12/10/24 at 12:10 p.m., the surveyor informed the ED that the log on information that she provided was not allowing the surveyor to access to the EMR. The ED stated that she would look into it.</p> <p>On 12/10/24 at 1:55 p.m., the surveyor was still not able to access the EMR and again made the ED aware that full EMR access was needed.</p> <p>The surveyor additionally requested specific policies and procedures from the Administrator that included Medication Administration, Staffing levels/acuity and Services provided to the facility residents.</p> <p>The ED provided several policies to the surveyor which included: Administering Medications, Resident Rights, New Employee Orientation and Comprehensive Assessments and the Care Delivery Process. The ED was unable to provide a specific policy regarding the description of services which the assisted living residence was capable of providing.</p>	A 539		
A 647	<p>8:36-6.1(a)(3) Resident Care Policies</p> <p>(a) Written resident care policies and procedures shall be established, implemented, and reviewed at intervals specified in the policies and procedures. Each review of the policies and procedures shall be documented. Policies and procedures shall include, but not be limited to, the following:</p> <p>3. The determination of staffing levels to ensure delivery of services and assistance as needed for each resident of the</p>	A 647		

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A 647	<p>Continued From page 23</p> <p>facility or program during each 24-hour period. Services may be provided directly by staff employed by the facility or program or in accordance with a written contract;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint: #NJ00181056</p> <p>Based on interview and review of records, it was determined that the facility failed to develop a policy that included a procedure to determine acuity based staffing levels to ensure the delivery of services and assistance for each resident of the facility, as needed, during each 24-hour period.</p> <p>On 12/10/24 at 11:10 a.m., during interview with the facility Administrator (ED), the surveyor requested a policy on Acuity Based Staffing Levels and the ED stated that she was not sure if the facility had that specific policy, but that she would check.</p> <p>During continued interview with the facility Administrator (ED), the surveyor asked where the facility policies and procedures were located, and the ED stated that all of the facility policies were electronic and that she believed they were located within the Electronic Medical Record system (EMR). The surveyor requested access to the facility EMR and requested several policies including a policy regarding staffing levels for acuity.</p> <p>On 12/10/24 at 12:10 p.m., the surveyor informed the ED that the log on information that she</p>	A 647		

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A 647	<p>Continued From page 24</p> <p>provided was not allowing the surveyor to access to the EMR. The ED stated that she would look into it.</p> <p>On 12/10/24 at 1:55 p.m., the surveyor was still not able to access the EMR and again made the ED aware that full EMR access was needed.</p> <p>The surveyor requested specific policies and procedures from the Administrator that included Medication administration, Staffing levels/acuity, and Services provided to the facility residents.</p> <p>The ED provided several policies to the surveyor which included: Administering Medications, Resident Rights, New Employee Orientation and Comprehensive Assessments and the Care Delivery Process. The ED was unable to provide a facility policy regarding Staffing levels and stated that she was unable to find one.</p>	A 647		
A 751	<p>8:36-7.3(b) Resident Assessments and Care Plans</p> <p>(b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record review and review of pertinent facility documents, it was determined that the facility failed to review and revise the Health Service Plan (HSP) for 1 of 8 residents reviewed, Resident #6. This deficient practice</p>	A 751		

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A 751	<p>Continued From page 25</p> <p>was evidenced by the following:</p> <p>On 1/31/25, the surveyor reviewed the Medical Record (MR) of Resident #6 which revealed [REDACTED]</p> <p>[REDACTED] The surveyor reviewed the "Order Summary Report" that revealed the following Physician's Order (PO): [REDACTED]</p> <p>[REDACTED]</p> <p>Continued surveyor review of the MR revealed Resident #6's service plan revealed two (2) dates, initiated on [REDACTED] and on [REDACTED] with a revision dated [REDACTED] "to [REDACTED] as ordered by the physician. Monitor for side effects and effectiveness Q (every) shift." The surveyor did not observe any documented evidence to show that Resident #2 was monitored or evaluated for any side effects or effectiveness of the medication every shift.</p> <p>During a telephone interview on 2/3/25 at 12:49 p.m. with the Director of Nursing (DON), in the presence of the Administrator, when the surveyor asked her how often HSPs were updated, she replied that the HSP was updated as needed, every 6 months and annually. She continued to say that our Point Click Care (computer program) does not separate the General Service Plan (the [REDACTED] NJ Ex Order 26. 4B1 [REDACTED] and the HSP, the document shows as "Service Plan" or "Care Plan".</p> <p>In the same interview, when the surveyor asked about Resident #6's service plan for the [REDACTED] NJ Ex Order 26. 4B1 [REDACTED] and how often the HSP was updated, the DON replied that the service</p>	A 751		

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A 751	<p>Continued From page 26</p> <p>plan was updated when the Pharmacy sends the list for a change in medications every 6 months or annually. When the surveyor asked her about the monitoring documentation of the adverse effects and effectiveness of medication every shift for Resident #6, the DON continued to say that the nurses do not do a flow chart and that there was only documentation done. If nurses observed a side effect, then a nurse's note was initiated..</p> <p>The facility failed to update Resident #6's HSP to ensure that goals, interventions, and effects of treatments were evaluated and reassessed for efficacy and adverse reactions. Resident #6's HSP was not updated and reviewed at least quarterly as required.</p> <p>Additionally, the facility facility ED was unable to provide documented evidence that the facility had a HSP policy.</p>	A 751		
A 783	<p>8:36-7.5(e) Resident Assessments and Care Plans</p> <p>(e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record</p>	A 783		

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A 783	<p>Continued From page 27</p> <p>review, it was determined that the facility failed to ensure that an annual physical examination included an annual physician certification that confirms that the resident's needs did not exceed the facility's ability to provide care and failed to maintain documentation of the certification in the resident's medical record for 1 of 8 residents reviewed, Resident #6. This deficient practice was evidenced by the following:</p> <p>On 1/31/25, the surveyor reviewed the Medical Record (MR) of Resident #6 which revealed [REDACTED]. The surveyor reviewed the MR and observed a History & Physical (H&P) "Health Assessment (HA)" dated [REDACTED] that included a section which indicated, "In your opinion, can this individual's needs be met in a residential facility that is not a medical, nursing or psychiatric facility (e.g., Assisted Living)? Yes ___ No ___." There was no answer and the section was left blank. There was no documentation provided that Resident #6 had an annual HA.</p> <p>On 1/31/25 at 2:59 p.m., the surveyor asked about how often the H&P/HA and Physician Certification (PC) requested by the surveyor was updated. The Licensed Practice Nurse (LPN) replied that they are done yearly.</p> <p>At 3:05 p.m., the surveyor interviewed the Administrator regarding the H&P/HA and PC, she stated that they were both due yearly. She stated that it is done within 30 days of admission and annually thereafter.</p> <p>The Administrator was unable to provide documented evidence of policies on H& P and Physician Certification during the survey. The</p>	A 783		
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A 783	Continued From page 28 Administrator confirmed that there were no policies on the H&Ps and Physician Certification.	A 783		
A 793	<p>8:36-8.2 Nursing Services</p> <p>A facility shall have at least one registered professional nurse available at all times.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint: #NJ00181056</p> <p>Based on interview and review of records it was determined that the facility failed to ensure that at least one Registered Professional Nurse was available at all times.</p> <p>On 12/4/2024 at 3:46 p.m., the New Jersey Department of Health (NJDOH) received a referral from the Office of the State Long-Term Care Ombudsman (LTCO) which indicated that on October 18th, 2024, five facility residents received medications from a Certified Nursing Assistant (CNA), who was not licensed to administer medications.</p> <p>On 12/10/24 at 11:40 a.m., the surveyor interviewed a facility Licensed Practical Nurse, (LPN #1) who stated that when she came to work on the morning of [REDACTED], she was told by a co-worker that a facility CNA had passed medications on the prior evening shift because there were two call outs. LPN #1 additionally stated that she called and notified the facility Administrator right away, and that the Administrator was aware that morning.</p> <p>1. On 12/10/24 the surveyor reviewed Resident</p>	A 793		

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A 793	<p>Continued From page 29</p> <p>#2's Medical Record (MR) which revealed a NJ Ex Order 26.4B1 [REDACTED].</p> <p>On 12/10/24 at 11:55 a.m., the surveyor interviewed a facility resident, Resident #2 who stated that the CNA administered his/her medications that were due at 4:00 p.m. on "that day" and that he/she remembered it well, because he/she NJ Ex Order 26.4(b)(1) the CNA. Resident #2 stated that it was the only time the CNA ever administered medications to him/her and that he was just doing what he was told to do. Resident #2 further stated that the DON was standing right there, and that she watched the CNA give the medications to Resident #2.</p> <p>At 12:14 p.m., the surveyor interviewed a facility LPN #2, who stated that on the date NJ Ex Order 26.4(b)(1) there were two nurses scheduled to work the 3:00 p.m. -11:00 p.m., shift. One of the nurses did not show up, and the other was an agency nurse who cancelled her shift. LPN #2 stated that she notified the DON that the same two nurses were scheduled to work the following evening, which was a Friday NJ Ex Order 26.4(b)(1), and that there was a concern for coverage. LPN #2 additionally stated that the DON indicated that she would work on the staffing; however, when the following evening came, no nursing coverage was found for the 3:00 p.m. -11:00 p.m. shift.</p> <p>During continued surveyor interview, LPN #2 stated that LPN #3 who was an agency nurse, had worked the 7:00 a.m.-3:00 p.m. shift, and ended up staying until between 5:30 p.m. and 6:00 p.m. that evening; however, an additional nurse was required for the second medication cart.</p>	A 793		

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A 793	<p>Continued From page 30</p> <p>On 12/10/24 at 3:20 p.m., the surveyor interviewed the facility CNA who stated that the DON asked him if he would help administer medications that evening since she could not find additional nursing coverage. The CNA further stated that the DON told him that since he had taken the Certified Medication Aide (CMA) class, it would be good practice for him. The CNA stated that he passed medications to four or five residents, but was only able to recall the names of three residents, Resident #2, Resident #3 and Resident #4.</p> <p>When the surveyor asked the CNA whether he NJ Ex Order 26. 4B1 to Resident #2, he stated that he did, and that was something he learned in CMA class. When the surveyor inquired about how he checked the NJ Ex Order 26. 4B1 or knew how much NJ Ex Order 26. 4B1 to give, he stated that Resident #2 had an "app" on his/ her phone that read the NJ Ex Order 26. 4B1, and that LPN #3, helped to determine the correct NJ Ex Order 26. 4B1 dose for the CNA to administer.</p> <p>The CNA stated that although he taken the CMA course, he had not yet been scheduled to take the exam, nor had he been trained to pass medications in the facility. When the surveyor inquired as to why he agreed to pass medications, he stated that sometimes when he feels nervous, he "tends to freeze up"; and, additionally that he wanted to follow the direction given to him by the DON. The CNA stated that LPN #3, showed him how to "work" the computer Electronic Medication System (EMR) to give the medications, and also gave him a quick overview of the medication cart. The CNA additionally stated that the DON was present with the CNA at that time, but then left after about a half hour.</p>	A 793		
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A 793	<p>Continued From page 31</p> <p>During continued interview, when the surveyor asked the CNA how he signed for the medications that he administered, he stated that LPN #3 logged him in under her name.</p> <p>The CNA further stated that a facility Certified Medication Aide (CMA) arrived to assist with medication pass that evening at approximately 5:30 p.m. or 5:45 p.m., which was when he stopped passing medications.</p> <p>2. On 12/11/24 the surveyor reviewed Resident #3's MR which revealed NJ Ex Order 26. 4B1 [REDACTED].</p> <p>On 12/11/24 at 10:55 a.m., during surveyor interview with Resident #3 he/she stated that the CNA administered his/her medications on one evening in NJ Ex Order 26.4(b) and that he/she was shocked but also grateful that to receive his/her medications. Resident #3 stated that usually in the evening, the nurse brought the medication to his/her apartment however when the nurse didn't come, Resident #3 went to the wellness office which was when the CNA gave the medications to him/her. Resident #3 further stated that evening was the only time he/she ever received medications from a CNA.</p> <p>On 12/11/24, at 11:41 a.m., the surveyor interviewed the DON who stated that the CNA should not have been passing medications that evening. The DON additionally stated that she told the CNA to help out however he could but did not specifically tell him to pass medications. The DON further stated that she was unaware that the CNA had passed medications to residents, until the Ombudsman came in and told her.</p>	A 793		

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A 793	<p>Continued From page 32</p> <p>When the surveyor asked the DON whether she investigated or completed an incident report, she stated that she had not. The DON further stated, "why would I do that if I'm the one being investigated?" The DON further stated that the Administrator should have done the investigation. The surveyor asked the DON if she knew which residents the CNA passed medications to, and she stated that she had no idea.</p> <p>When the surveyor asked the DON why she did not stay to pass medications on the evening of NJ Ex Order 26.4(0), when she could not find proper nursing coverage, she stated that she had an emergency. When the surveyor asked if there was another Registered Nurse (RN) available when she was unavailable, on vacation, or when there were staffing issues, the DON stated that she was the only RN on staff and on call and that there was noone else.</p> <p>On 12/10/24 at 11:10 a.m., during interview with the facility Administrator (ED), the surveyor requested a policy on acuity based staffing levels, and the ED stated that she was not sure if the facility had a specific policy, but that she would check.</p> <p>The ED was unable to provide a facility policy regarding staffing levels and stated that she was unable to find one.</p>	A 793		
A 935	<p>8:36-11.4(b) Pharmaceutical Services</p> <p>(b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings,</p>	A 935		

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A 935	<p>Continued From page 33 and all Federal and State laws and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint: #NJ00181056</p> <p>Based on interview and review of records, it was determined that the facility failed to ensure that all medications were properly administered and documented by qualified personnel, in accordance with all State laws and regulations, by allowing a Certified Nursing Assistant to administer medications to 3 of 8 residents reviewed, Resident#s 2, 3 and 4. This deficient practice was evidenced by the following:</p> <p>On 12/10/24 at 11:40 a.m., the surveyor interviewed a facility Licensed Practical Nurse, (LPN #1) who stated that when she came to work on the morning of [redacted], she was told by a co-worker that a facility CNA had passed medications on the prior evening shift because there were two nursing call outs. LPN #1 additionally LPN #1 stated that she called and notified the facility Administrator right away, and that the Administrator was aware that morning.</p> <p>1. On 12/10/24, the surveyor reviewed Resident #2's Medical Record (MR) which revealed [redacted]</p>	A 935		

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A 935	<p>Continued From page 34</p> <p>On 12/10/24 at 11:55 a.m., the surveyor interviewed a facility resident, Resident #2 who stated that the CNA administered his/her medications that were due at 4:00 p.m. on "that day" and remembered it well, because he/she [REDACTED] the CNA. Resident #2 stated that it was the only time the CNA ever administered medications to him/her and that he was just doing what he was told to do. Resident #2 further stated that the DON was standing right there, and that she watched the CNA give medications to Resident #2.</p> <p>At 12:14 p.m., the surveyor interviewed a facility LPN #2, who stated that on the date of [REDACTED] there were two nurses scheduled to work the 3:00 p.m. -11:00 p.m., shift . One of the nurses did not show up, and the other was an agency nurse who canceled her shift. LPN #2 stated that she notified the DON that the same two nurses were scheduled to work the following evening, which was a Friday [REDACTED], and that there was a concern for coverage. LPN #2 additionally stated that the DON indicated that she would work on the staffing; however, when the following evening came, no nursing coverage was found for the 3:00 p.m. -11:00 p.m. shift on [REDACTED]</p> <p>During continued surveyor interview, LPN #2 stated that LPN #3 who was an agency nurse, had worked the 7:00 a.m.-3:00 p.m., and ended up staying until between 5:30 p.m. and 6:00 p.m.; however, an additional nurse was required for the second medication cart.</p> <p>On 12/10/24 at 3:20 p.m., the surveyor interviewed the facility CNA who stated that the DON asked him if he would help administer medications that evening since she could not find</p>	A 935		

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A 935	<p>Continued From page 35</p> <p>additional nursing coverage. The CNA further stated that the DON told him that since he had taken the Certified Medication Aide (CMA) class, it would be good practice for him. The CNA stated that he passed medications to four or five residents, but was only able to recall the names of three residents, Resident #2, Resident #3 and Resident #4.</p> <p>When the surveyor asked the CNA whether he NJ Ex Order 26. 4B1 to Resident #2, he stated that he did, and that was something he learned in CMA class. When the surveyor inquired about how he checked the NJ Ex Order 26. 4B1 or knew how much NJ Ex Order 26. 4B1 to give, he stated that Resident #2 had an "app" on his/ her phone that read the NJ Ex Order 26. 4B1, and that LPN #3, helped to determine the correct NJ Ex Order 26. 4B1 dose for the CNA to administer.</p> <p>The CNA stated that although he taken the CMA course, he had not yet been scheduled to take the exam, nor had he been trained to pass medications in the facility. When the surveyor inquired as to why he agreed to pass medications, he stated that sometimes when he feels nervous, he "tends to freeze up" and that he wanted to follow the direction given to him by the DON. The CNA stated that LPN #3, showed him how to "work" the computer Electronic Medication System (EMR) to give the medications, and also gave him a quick overview of the medication cart. The CNA additionally stated that the DON was present with the CNA at that time, but then left after about a half hour.</p> <p>During continued interview, when the surveyor asked the CNA how he signed for the medications that he administered, he stated that LPN #3, logged him in under her name.</p>	A 935		

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A 935	<p>Continued From page 36</p> <p>The CNA further stated that a facility Certified Medication Aide (CMA) arrived to assist with medication pass that evening at approximately 5:30 p.m. or 5:45 p.m., which was when he stopped passing medications.</p> <p>2. On 12/11/24 the surveyor reviewed Resident #3's MR which revealed NJ Ex Order 26. 4B1 [REDACTED].</p> <p>On 12/11/24 at 10:55 a.m., during surveyor interview with Resident #3 he/she stated that the CNA administered his/her medications on one evening in NJ Ex Order 26.4(b) and that he/she was shocked, but also grateful to receive his/her medications. Resident #3 stated that usually in the evening, the nurse brought the medication to his/her apartment; however, when the nurse didn't come, Resident #3 went to the wellness office which was when the CNA administered the medications to him/her. Resident #3 further stated that evening was the only time he/she ever received medications from a CNA.</p> <p>3. The surveyor reviewed the Resident #4's MR which revealed a NJ Ex Order 26. 4B1 [REDACTED]. Resident #4 was not available for interview.</p> <p>On 12/11/24, at 11:41 a.m., the surveyor interviewed the DON who stated that the CNA should not have been passing medications that evening. The DON additionally stated that she told the CNA to help out however he could, but did not specifically tell him to pass medications. The DON further stated that she was unaware that the CNA had passed medications to</p>	A 935		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20C100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2025
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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VICTORIA COMMONS, LI	STREET ADDRESS, CITY, STATE, ZIP CODE 610 TOWNBANK ROAD NORTH CAPE MAY, NJ 08204
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A 935	<p>Continued From page 37</p> <p>residents, until the Ombudsman visited and told her.</p> <p>When the surveyor asked the DON whether she investigated or completed an incident report, she stated that she had not. The DON further stated, "why would I do that if I'm the one being investigated?" The DON further stated that the Administrator should have done the investigation. The surveyor asked the DON if she knew which residents the CNA passed medications to, she responded and stated that she had no idea.</p> <p>When the surveyor asked the DON why she did not stay to pass medications on the evening of NJ Ex Order 26.4(b)(1) when she was unable to find proper nursing coverage, she stated that she had an emergency. When the surveyor asked if there was another Registered Nurse (RN) available when she was unavailable, on vacation, or when there were staffing issues, the DON stated that she was the only RN on staff.</p> <p>Agency LPN #3's phone number was provided to the surveyor by the facility, however LPN #3 did not answer the phone on the dates of 12/11/24, 12/12/24 and 12/17/24.</p> <p>On 12/17/24 at 10:45 a.m., during surveyor interview with the facility Administrator (ED), she stated that she was not notified that the CNA had passed medications until the Monday after that weekend, but that she could not recall who told her.</p> <p>The ED additionally stated that from what she could remember, the DON found out about the CNA passing medications on that Monday as well. The ED stated that a formal investigation was not done, however when she looked into it</p>	A 935		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20C100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2025
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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VICTORIA COMMONS, L	STREET ADDRESS, CITY, STATE, ZIP CODE 610 TOWNBANK ROAD NORTH CAPE MAY, NJ 08204
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A 935	<p>Continued From page 38</p> <p>and asked the CNA whether he administered medications to the residents, he stated that he didn't. The ED stated that she spoke to LPN #3 who also denied that the CNA administered medications. The ED stated based on what the CNA and LPN #3 said, she didn't investigate further.</p> <p>Surveyor review of a facility policy titled, "Administering Medications" with an updated date of 10/2022, revealed the following: "...1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so....."</p> <p>During the time of survey, a Removal Plan (RP) was requested to ensure immediate corrective actions are taken remove the immediacy of thee situation.</p> <p>On 1/31/25, a Revisit survey was conducted to verify that the Removal Plan (RP) was implemented. However, the Revisit survey revealed that the RP was not implemented to include the following as indicated in their RP: in-services on medication administration and documentation to all LPNs and CMAs and in-services to all CNAs to work within the scope of their certification and job description and a Policy and Procedure was not developed concerning incidents and investigations.</p>	A 935		
A1051	<p>8:36-15.2 Resident Records</p> <p>The records required by this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department.</p>	A1051		

New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT VICTORIA COMMONS, L	STREET ADDRESS, CITY, STATE, ZIP CODE 610 TOWNBANK ROAD NORTH CAPE MAY, NJ 08204
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A1051	<p>Continued From page 39</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure requested Electronic Medical Records (EMRs) were available to review upon ssurvey entrance on 12/10/24 for 5 of 5 residents, Resident #'s 1, 2, 3, 4, 5 and upon entrance on 1/31/25 for 3 of 3, Resident #'s 6,7,and 8. This deficient practice was evidenced by the following:</p> <p>1. On 12/10/24 at entrance, the surveyor requested full access to the EMRs; however, the surveyor was not provided access to requested EMRs. During the exit conference that first survey day on 12/10/24, the Administrator informed the surveyor that full access to the EMRs was still not working, and she would ensure access would be provided the next day.</p> <p>On 12/11/24, the second day of survey, at 12:45 p.m., the Director of Nursing stated there was still no full access granted to the EMRs.</p> <p>At 1:10 p.m., a Maintenance staff came in with tech support on the phone.</p> <p>At 1:20 p.m., the Administrator stated that she would give the surveyor her full access.</p> <p>At 1:34 p.m., full access was granted, at the time the surveyor was preparing to exit.</p> <p>2. On 1/31/25 at 9:58 a.m., during a Revisit survey, the surveyor requested full access to the facility's EMRs, upon the Administrator's arrival at the facility. The Administrator stated that she would be able to provide the surveyor with full</p>	A1051		

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A1051	<p>Continued From page 40</p> <p>access to the EMR.</p> <p>At 10:13 a.m., the Administrator was still trying to get the surveyor complete access to the EMR, but the system was requesting a unique long username login.</p> <p>At 11:13 a.m., the Administrator stated that the access was previously deleted by the corporate person and that the EMR access was granted to the surveyor.</p> <p>At 12:00 p.m., the surveyor tried to login and the login did not work.</p> <p>At 12:15 p.m., the Administrator stated that the Receptionist was working on obtaining the surveyor's access to the EMR.</p> <p>At 12:19 p.m., the Receptionist stated that corporate was working on the EMR access for the surveyor.</p> <p>At 1:40 p.m., the surveyor checked on the status of the EMR access and login, the Administrator stated that she was waiting for a response from corporate.</p> <p>At 1:45 p.m., the Administrator provided the surveyor with a new login.</p> <p>The surveyor was not granted full access to the EMRs at the ttime of request. The EMRs were not available for review which affected and impeded the New Jersey Department of Health's survey and investigation process.</p>	A1051		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 20C100 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/18/2025 Y3
NAME OF FACILITY COMPLETE CARE AT VICTORIA COMMONS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 610 TOWNBANK ROAD NORTH CAPE MAY, NJ 08204

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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 02/05/2025	ID Prefix A0312 Reg. # 8:36-3.4(a)(3) LSC	Correction Completed 01/31/2025	ID Prefix A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 02/05/2025
ID Prefix A0539 Reg. # 8:36-5.7(a)(2) LSC	Correction Completed 06/01/2025	ID Prefix A0647 Reg. # 8:36-6.1(a)(3) LSC	Correction Completed 01/31/2025	ID Prefix A0793 Reg. # 8:36-8.2 LSC	Correction Completed 05/15/2025
ID Prefix A0935 Reg. # 8:36-11.4(b) LSC	Correction Completed 01/31/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/31/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 20C100	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/18/2025
Y1	Y2	Y3
NAME OF FACILITY COMPLETE CARE AT VICTORIA COMMONS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 610 TOWNBANK ROAD NORTH CAPE MAY, NJ 08204

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0312	Correction	ID Prefix A0401	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-3.4(a)(3)	Completed	Reg. # 8:36-4.1(a)(22)	Completed
LSC	02/05/2025	LSC	01/31/2025	LSC	02/05/2025
ID Prefix A0515	Correction	ID Prefix A0539	Correction	ID Prefix A0647	Correction
Reg. # 8:36-5.6(a)	Completed	Reg. # 8:36-5.7(a)(2)	Completed	Reg. # 8:36-6.1(a)(3)	Completed
LSC	02/28/2025	LSC	06/01/2025	LSC	01/31/2025
ID Prefix A0751	Correction	ID Prefix A0783	Correction	ID Prefix A0793	Correction
Reg. # 8:36-7.3(b)	Completed	Reg. # 8:36-7.5(e)	Completed	Reg. # 8:36-8.2	Completed
LSC	02/04/2025	LSC	02/04/2025	LSC	05/15/2025
ID Prefix A0935	Correction	ID Prefix A1051	Correction	ID Prefix	Correction
Reg. # 8:36-11.4(b)	Completed	Reg. # 8:36-15.2	Completed	Reg. #	Completed
LSC	01/31/2025	LSC	01/31/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/31/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		