STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315178	A. BUILDING _____ B. WING _____	C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE EAST ORANGE, NJ 07017

(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 #: NJ152448, NJ152897, NJ153708, NJ154069 and NJ157542 Census: 181 Sample Size: 16 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. Survey date: 01/23/2023 - 01/25/2023	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		2/1/23

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

Electronically Signed | 02/15/2023

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 609	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ153708 Based on record review, interviews, and facility policy review, it was determined that the facility failed to report an injury of unknown origin to the required entities for 1 (Resident #3) of 3 residents reviewed for injuries of unknown origin. Specifically, the facility failed to report to the state agency when Resident #3 was identified to have bruising on the hand that was later identified as fractured fingers. Findings included: The facility's policy, titled, "Unusual Occurrence Reporting," revised January 2021, indicated, "As required by federal or state regulation, our facility reports unusual occurrences [that] occurred at the facility premises or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors." The policy further specified, "Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations." A review of Resident #3's "Admission Record" revealed the facility admitted the resident with diagnoses that included EX. Order 26.(4) B1 [redacted]	F 609	1) The resident no longer resides at the facility 2)All residents have the potential to be affected by this incident. 3)The Administrator and the Director of Nursing were in serviced on Federal Regulation F609 and on the NJDOH reportable event grid, by the regional Clinical Consultant on 1/25/23. 4)The Director of Nursing or her designee will audit all incidents to ensure incidents are reported per guidelines weekly X4, and then 5 incidents monthly X2, with results reported to administrator at the Quality Assurance Performance Improvement Committee that meets monthly.	

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EX. Order 26.(4) B1

A review of the five-day Minimum Data Set (MDS), dated EX. Order 26.(4) B1, revealed Resident #3 had EX. Order 26.(4) B1 for EX. Order EX. Order 26.(4) B1, per the Staff Assessment for Mental Status. The resident required extensive to total assistance with their activities of daily living (ADLs). The resident had no EX. Orde prior to the assessment.

A review of Resident #3's "Care Plan," initiated on EX. Order 26.(4) B1, indicated the resident was at risk for EEX. Orde related to EX. Order 26.(4) B1 problems. Interventions included to anticipate and meet the resident's needs; be sure call light was within reach and encourage the resident to use it for assistance as needed; and the resident needed prompt response to all requests for assistance.

The "Care Plan," initiated on EX. Order 26.(4) B1 revealed Resident #3 was EX. Order 26.(4) B1 with EX. Order 26.(4) B1 on their EX. Order 26.(4) B1

The "Care Plan," initiated on EX. Order 26.(4) B1 indicated Resident #3 was EX. Order 26.(4) B1. Interventions included: If the resident resisted with ADLs, reassure the resident, leave, and return 5 to 10 minutes later and try again; EX. Order 26.(4) EX. Order 26.(4) B to prevent injury; two staff members to assist with hygiene care; provide consistency in care to promote comfort with ADLs; and maintain consistency in timing of ADLs, caregivers and routine, as much as possible.

A review of the "Progress Notes," revealed a nurse's note, dated EX. Order 26.(4) B1 indicating

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Resident #3's EX. Order 26.(4) B1 and EX. Order 26.(were observed to be EX. OrOrder 26.(with a EX. Order 26.(4) B1 when the nurse went to check the resident's EX. Order 26.(4) B1 at 7:30 AM. The note indicated Resident #3 only spoke EX. Order 26.(4) B1, and the resident told a EX. Order 26.(4) B -speaking Certified Nurse Aide (CNA) they had EX. Order 2 and had complaints of EX. Order 26.(4) B1 and EX. Order 26.(. The note indicated the resident was seen by the Nurse Practitioner (NP), who ordered EX. Order 26.(

A review of the "Progress Notes" revealed a physician progress note, dated EX. Order 26.(4) B1, indicating Resident #3 had EX. Order 26.(4) B with EX. Order 26.(4) B and EX. Order 26.(4) B1 cause to their EX. Order 26.(4) B1 including the EX. Order 26.(4) B1 and EX. Order 26.(4) B1. The plan was to obtain EX. Order 26.(.

A review of a EX. Order 26.(4) B1 Results Report," dated EX. Order 26.(4) B1 indicated Resident #3 had fractures of the EX. Order 26.(and EX. Order 26.(4) B1 on the EX. Order 26.(4) B1 and the EX. Order 26.(4) B1 could not be determined.

A review of the incident report, dated EX. Order 26.(4) B1, indicated the resident could be EX. Order 26.(EX. Ord and EX. Order 26.(4) B1.

A review of the facility's investigation of the bruise, dated EX. Order 26.(4) B1, indicated the nurse reported Resident #3's EX. Order 26.(4) B1 was EX. Order 26.(4) B and EX. Order 26.(4) B1. The investigational summary indicated the resident's EX. Order 26.(4) B on the bed were to be EX. Order 26.(4) to prevent injury. A review of the witness statements from staff that cared for Resident #3 and were working prior to and at the time of the EX. Order 26.(4) B1 incident revealed the resident did not have a EX. O, and the resident was not involved in any type of known incident.

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A review of the "Progress Notes" revealed a general note, dated EX. Order 26.(4) B1, indicating EX. Order 26 results were received and called to the physician with orders to send the resident to the hospital for evaluation. The note indicated Resident #3 was sent out to the hospital for evaluation at 12:07 AM and returned back to the facility at 5:18 AM with a EX. Order 26.(4) B1. The note indicated the resident was combative with the Emergency Medical Service (EMS) staff, attempting to hit them, and removed the EX. Order 26

A review of the "Progress Notes" revealed a physician progress note, dated EX. Order 26.(4) B1, indicating Resident #3 had fractures to the EX. Order 2 and EX. Order 26.(4) B1 with EX. Order 26.(4) B1 and the EX. Order 26.(4) B1 could not be determined. The note indicated the plan was to EX. Order 26.(4) B1 and EX. Order 26.(, and that the resident had been noncompliant so far. The note further indicated to apply EX. O to the resident's EX. Order 26.(4) B1 times a day, elevate the EX. Order 26.(4) B1, and discontinue the EX. Order 26.(4) B1 due to the risk being greater than the benefits. The note indicated the staff reported the resident was EX. Order 26.(4) B1 with the EX. Order 26 ripped it off, and would not allow staff to reapply it. The note indicated the resident had a history of EX. Order 26.(4) B1, and EX. Order 26.(4) B1.

A review of the "Progress Notes" revealed a physician progress note, dated EX. Order 26.(4) B1 indicating the resident's EX. Order 26.(4) B1 and EX. Order 26.(4) B1 EX. Order 26.(4) B1 were suggestive of a EX. Order 26.(4) B1 process due to EX. Order 26.(4) B1 after review of all the information and EX. Order 26.(4) B1 findings.

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A copy of the report submitted to the state agency for an injury of unknown origin was requested from the facility on EX. Order 26.(4) B1 and was not provided by the end of the survey.

During an interview on 01/25/2023 at 9:38 AM, the Director of Nursing (DON) stated at first they thought Resident #3 obtained the EX. Order 26.(4) B1 from a EX. Order since that was what the resident reported to their EX. Order 26.(4) B1-speaking CNA, but after the investigation that included the Physician Assistant (PA) and the Medical Director (MD), it was determined the resident did not fall but had a EX. Order 26.(4) B1 that occurred due to a disease). The DON stated the resident was on an EX. Order 26.(4) B1 medication) and was EX. Order 26.(4) B1. She stated the intervention they put into place was to EX. Order 26.(4) B1 on the bed, and the resident was to wear a splint on their hand, which they were EX. Order 26.(4) B1 with. The DON stated she did not consider the incident to be something that would need to be reported to the state since they had determined the cause but then did agree that it should have been reported before the investigation occurred and not during or after.

During an interview on 01/25/2023 at 12:44 PM, the Administrator stated Resident #3 was on an EX. Order 26.(4) B1 that caused the EX. Order 26.(4) B1, and the fracture was determined to be EX. Order 26.(4) B1. He stated it was an injury of unknown origin when it was found and should have been reported, per their policy.

New Jersey Administrative Code § 8:39-9.4(f)