STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. BUILDING _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MADISON, LLC	**625 STATE HIGHWAY 34 MATAWAN, NJ 07747**

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F 000	INITIAL COMMENTS Complaint NJ #: 163503, 163699, 164917, 165994, 167427, 170365, 171611, 172074, 172747, 174114, 175564 Survey Date: 8/27/24 Census: 118 Sample: 38 + 2 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 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and observation, it was determined that the facility failed to a.) ensure staff did not use their cell phones in resident care areas and while performing resident care; and b.) ensure staff did not speak in a non-English language while rendering care to English-speaking residents. This deficient practice was identified by 4 of 4 residents during the Resident Council group meeting (Resident	F 557	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #9, #14, # 57 and #79 were all affected by the deficient practice. CNA #1 was immediately educated on facility policy on use of cell phone/ blue tooth earpiece while working on the units.	9/19/24

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

Electronically Signed | 09/13/2024

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 557	Continued From page 1 #9, #14, #57, and #79) and evidenced by the following: On 8/21/24 at 10:02 AM, the surveyor conducted a resident group meeting with four residents who were alert and oriented and selected by the facility to attend the group meeting. All four residents complained that staff, both certified nursing aides (CNAs) and nurses were on their phones and some spoke in a foreign language on the phone when providing resident care. Resident #14 and Resident #57 stated that nurses were on their bluetooth earpieces on the phone when preparing and administering medications, and they both were given incorrect medications that they refused to take. All four residents agreed it was an issue, and the facility was aware of it, but nothing was done. All four residents felt that since COVID, there have been staffing shortages, so the facility let the staff in the facility do whatever they wanted with no repercussions. On 8/21/24 at 11:59 AM, the surveyor interviewed the facility's U.S. FOIA (b)(6) who stated that residents have complained about staff on their cell phones, and she conducted formal education as well with staff. The U.S. FOIA stated that staff was not to be on their cell phone. At that time, the surveyor requested a copy of the facility's cell phone policy and inservice conducted. On 8/21/24 at 12:25 PM, the surveyor observed CNA #1 in the hallway with a bluetooth earpiece in her ear. The surveyor did not observe CNA #1 actively in a phone conversation. On 8/21/24 at 1:03 PM, the surveyor reviewed the Inservice 7/25/24, provided by the U.S. FOIA, which	F 557	Blue tooth earpiece was immediately removed. Department heads performed unit audits and no other staff were found with blue tooth device in their ear. 2. How the facility will identify other resident having the potential to be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. All staff were immediately educated on dignity and respect. No other resident was affected by the deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: All facility staff were educated on a) facility policy on cell phone/ blue tooth use b) speaking foreign languages while in resident care areas of English-speaking residents. All staff were immediately educated on dignity and respect. The DON/ Designee will randomly interview residents that are alert and oriented who speak primarily English to ensure that staff speaks English on the unit and have no blue tooth earpiece on while rendering care or on the units. If any staff is identified with the deficient practice progressive discipline will be initiated. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The Director of Nursing or designee will conduct unit audits weekly x 4 and monthly x2 on 5 residents to determine staff compliance with facility policy on cell phone/ blue tooth use and speaking foreign language in resident care areas of	

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F 557	Continued From page 2 included no cell phone, headphones or ear buds allowed on the floor; must use in breakroom, and only speak English around English-speaking residents. On 8/26/24 at 10:18 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]), who stated staff were reminded to speak in English in resident care areas and resident rooms. The [redacted] stated that staff were expected to not use personal phones in resident care areas, as well as staff should not be using bluetooth earpieces, even if they were not providing resident care. The [redacted] stated there were no cell phones allowed on the floor or during care because it was disrespectful to the residents. On 8/27/24 at 9:50 AM, the U.S. FOIA (b)(6) [redacted]) in the presence of the [redacted] and survey team, stated that the residents had a concern with staff cell phone usage that the [redacted] addressed in July. The [redacted] acknowledged it was still a concern. The surveyor asked if the facility disciplined staff for using their cell phones, and the [redacted] stated not since the meeting but the facility had in the past. The surveyor asked what happened to the staff who was found using their phone, and the [redacted] stated the facility only suspended staff during investigations for abuse, and the staff would be written up for a cell phone. The surveyor requested a copy of any staff write-ups for cell phone usage. No additional information was provided. A review of the facility's "Resident Rights" policy dated updated April 2024, included federal and	F 557	English-speaking residents. 5. The results of the audit will be submitted and reviewed to the QAPI committee quarterly to ensure that facility's corrective action for the deficient practice will not recur.	

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F 557	Continued From page 3 state laws guarantee certain basic rights to all residents of this facility. These rights include resident's right to include but not limited to:...to be treated with respect, kindness, and dignity...have facility respond to his or her grievances... A review of the untitled facility provided policy dated January 2022 Edition, included Personal Electronic Device...workplace use of these devices can raise a number of issues involving safety, security, and privacy...employees should conduct personal business during meal breaks and other rest periods. This includes the use of personal communication devices...violation of this policy may result in discipline, up to and including termination of employment. NJAC 8:39-4.1(a)12	F 557		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered;	F 622		9/18/24

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F 622	Continued From page 4 (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this	F 622		

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F 622	Continued From page 5 section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to document complete and appropriate information on the New Jersey Universal Transfer Form (UTF) to communicate with the Emergency Room (ER) where a resident was being transferred, or to have a policy and procedure for UTF. This deficient practice was identified for 1 of 2 residents reviewed for hospitalization (Resident #100), and was	F 622	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 100 was affected by the NJ Exec Order 26.4b1 and was readmitted to the facility on NJ Exec Order 26.4b and unable to correct -two incomplete universal transfer forms. 2. How the facility will identify other	

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F 622	Continued From page 6 evidenced by the following: Reference: NJ.gov: https://www.nj.gov/health/forms/hfel-7instr_1.pdf: "INSTRUCTIONS FOR COMPLETING THE NEW JERSEY UNIVERSAL TRANSFER FORM" dated "Aug 11", The purpose of the New Jersey Universal Transfer Form: A form that communicates pertinent, accurate clinical patient care information at the time of a transfer between health care facilities/programs. It conveys the patient information required under federal regulations and conveys specific facts that the physician and nurse need to begin caring for a patient. The word patient is used throughout the form, but refers to resident/client or the terminology used by a specific facility or program. Complete all boxes #1 - 29. On 8/27/24 at 10:30 AM, the surveyor reviewed the medical record for Resident #100. A review of the Admission Record face sheet (an admission summary) revealed the resident had diagnoses which included but were not limited to; [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a brief interview for mental status (BIMS) score of [redacted], indicating a [redacted]. A further review of Active Diagnoses included [redacted]	F 622	resident having the potential to be affected by the deficient practice: All residents that may be transferred to another facility will have the potential to be affected by the deficient practice. All resident transfers in the last 30 days were reviewed and none were affected by the deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: Nurses that failed to complete identified universal transfer form were educated on the importance of providing a completed universal transfer form. Unit Managers were educated by the DON/ Designee to ensure that all universal transfer forms are accurately completed. All nurses were educated by DON on importance of completion of Universal transfer form . 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The Director of Nursing or designee will conduct a weekly audit on 1 universal transfer form x 4 weeks, then monthly x 2 months to ensure universal transfer were filled out and completed accurately 5. The results of the audit will be submitted and reviewed to the QAPI committee quarterly to ensure that facility□s corrective action for the deficient practice will not recur. the QAPI committee meets quarterly.	

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F 622	Continued From page 7 A review of the Order Summary Report for [redacted], the physician's order (PO) dated [redacted], for NJ Ex Order 26.4b1 [redacted] ... for diagnosis [redacted]. A review of the individualized comprehensive care plan (ICCP) included but not limited to the focus areas of ; Advanced Directives [redacted] potential to be [redacted] ... threaten staff with [redacted] which included, when [Resident # 100] became [redacted] [...]; an [redacted] and as having had an [redacted] requires [redacted] related to [redacted] with an intervention to educate staff, resident, family and visitors ...of [redacted] A review of the Progress Note (PN) dated [redacted] at 9:35 AM, indicated Resident #100 had begun shouting, [redacted]"; resident became [redacted] into nursing station. The nurse called emergency services, and the resident was taken to [name redacted] hospital Emergency Room via ambulance. A review of the PN dated [redacted], revealed that Resident #100 had returned to the facility. A review of the PN dated [redacted], indicated Resident #100 was [redacted] and expressing [redacted] the secured unit. Resident was placed on [redacted]. A review of the PN dated [redacted],	F 622		

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F 622	Continued From page 8 the US FOIA (b)(6) documented that Resident #100 still had NJ Exec Order 26.4b1 NJ Ex Order 26.4b1 [redacted]. Resident was transported to the Emergency Room. A review of the two UTFs, which documented on the top of the form "Items 1 - 29 must be completed" revealed the following: The first undated form revealed the reason for transfer as NJ Exec Order 26.4b1 [redacted] and the following areas were left blank: #2 date and time; #6 code status; #9 primary diagnosis including "mental health diagnosis (if applicable); #12 isolation precautions with option for "none"; #18 personal items sent with patient with option for "none"; #20 at risk alerts with option for "none"; #21 mental status; #22 PASRR (pre-admission screening and resident review which indicates mental illness status); #23 function with option "self"; #25 bowels; #26 bladder; #27 no phone number of the facility sending the resident out for evaluation; and #29 who completed the UTF form. The first UTF indicated that only Resident #100's "Face Sheet" was attached and no other documents. The second undated form revealed the following areas were left blank: #1 transfer to what facility; #2 time of transfer; #6 code status; #8 reason for transfer; #9 primary diagnosis; #12 isolation precautions with option for "none"; #18 personal items sent with patient with options for "none"; #19 attached documents; #22 PASRR; #27 sending facility contact information; and #29 who completed the UTF form.	F 622		

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F 622	Continued From page 9 On 8/26/24 at 11:13 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted], who stated if a resident was being sent out to the hospital, the staff completed the transfer form [UTF]. The U.S. FOIA (b)(6) further stated that the staff informed the transport staff verbally and that it was important in case the [hospital] staff did not "get to the resident right away". On 8/26/24 at 1:05 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] who stated that the facility had no policy or procedure for the staff to follow regarding the use of the UTF. The surveyor reviewed the two undated UTFs with the U.S. FOIA (b)(6), who stated that the staff did not have to fill out all areas of the form regardless of the instructions on the form, but to "just to fill out only relevant areas". On 8/27/24 at 9:50 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) [redacted]) and survey team stated that the medical records department, or the unit clerk were responsible to upload the UTF to the electronic medical record, but that was not done immediately. At that time, the U.S. FOIA (b)(6) stated that the nurse who was sending the resident out was to ensure the UTF was completed prior to the resident leaving. A review of the facility provided policy, "Transfer or Discharge, Emergency" dated revised 12/1/22, ...4.d. Prepare a universal transfer form to send with the resident...	F 622		
F 657 SS=D	NJAC 8:39-4.1(a)31 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		9/9/24

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F 657	Continued From page 10 §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) 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: Complaint NJ #:171611 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to revise an individual comprehensive care plan for a resident with a NJ Exec Order 26.4b1. This deficient practice was identified for 1 of 2 residents reviewed for NJ Exec Order 26.4b1 (Resident #3), and was evidenced	F 657	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 3's comprehensive care plan was immediately reviewed and updated to reflect NJ Ex Order 26.4b1 DON, IP, and Unit Managers reviewed care plans of residents [redacted] ds and no other	

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F 657	Continued From page 11 by the following: On 8/19/24 at 11:20 AM, the surveyor observed the U.S. FOIA (b)(6)) outside Resident #3's room putting on personal protective equipment (PPE) prior to entering the room. The U.S. FOIA (b) stated that the resident was on NJ Ex Order 26.4b1 and staff were required to were PPE prior to entering the room. On 8/20/24 at 1:31 PM, the surveyor reviewed the medical record for Resident #3. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included NJ Exec Order 26.4b1 A review of the most recent quarterly Minimum Data Set, and assessment tool dated NJ Exec Order 26.4 indicated that the resident had NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b A further review revealed the resident had NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Ex Order 26.4b1 as well as the resident was on the NJ Ex Order 26.4b1 program. A review of the Order Summary Report included a physician's order (PO) dated NJ Exec Order 26.4, to cleanse ; apply NJ Exec Order 26.4b1	F 657	resident was affected by the deficient practice. 2. How the facility will identify other resident having the potential to be affected by the deficient practice: All residents have the potential to be affected by the deficient practice What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: The DON/ Designee reeducated the US FOIA on the comprehensive care plan process. The UM will review residents with wounds and any facility acquired wounds will be updated on the comprehensive care plan. Unit Managers will review weekly wound consult sheet for any changes on wound condition, treatment and update care plan as needed. 3. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The Director of Nursing or designee will audit 5 residents with wounds to ensure that the wounds are reflected in the care plans in a timely manner. This audit will be performed weekly x 4weeks then monthly x 2. 4. 5. The results of the audit will be submitted and reviewed to the QAPI committee monthly/ quarterly to ensure that facility's corrective action for the deficient practice will not recur.	

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F 657	Continued From page 12 and NJ Ex Order 26.4b1 [redacted] every shift for [redacted] care. A review of the individualized comprehensive care plan (ICCP) included a focus area dated [redacted] and last revised on [redacted], that the resident had potential for NJ Exec Order 26.4b1 [redacted] with regards to immobility. Interventions included to NJ Ex Order 26.4b1 [redacted] while in bed; educate resident/family/caregivers of causative factors and measures to prevent [redacted]; encourage me to NJ Ex Order 26.4b1, and follow facility protocols for treatment of injury. The ICCP did not include the residents actual NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 [redacted]. On 8/22/24 at 1:24 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] who stated she was in charge of completing and updating residents' ICCPs. The [redacted] stated ICCPs were updated daily for any changes, and the care plan included but not limited to: behaviors, wounds, skin integrity, treatments, medications, fall risks, and preventative care. The [redacted] stated Resident #3 had a NJ Exec Order 26.4b1 [redacted], and they were followed by the [redacted] doctor. The [redacted] stated that the resident NJ Ex Order 26.4b1 frequently and the Physician wanted the resident out of bed limited time because they favored the right side, and put NJ Exec Order 26.4b1 [redacted]. The [redacted] continued the Physician also recommended a [redacted] as a NJ Ex Order 26.4b1 [redacted] when out of bed to NJ Ex Order 26.4b1. At that time, the surveyor with the [redacted] reviewed the resident's ICCP, and she confirmed the care plan did not include the resident's [redacted]	F 657		

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F 657	Continued From page 13 On 8/22/24 at 1:52 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated ICCPs were updated quarterly and as needed. At that time, the surveyor and the U.S. FOIA (b)(6) reviewed the resident's ICCP, and the U.S. FOIA (b)(6) confirmed the ICCP did not include the resident's U.S. FOIA (b)(6), and it should have. On 8/26/24 at 1:33 PM, the Acting DON in the presence of the U.S. FOIA (b)(6)) and survey team stated that in the resident's focus area for their NJ Exec Order 26.4b1 was marked as "resolved" in NJ Ex Ord when their NJ Exec Order 26.4b1 , but the focus area for the U.S. FOIA (b)(6) should have remained. The U.S. FOIA (b) acknowledged there was no active focus area for the NJ Ex Order 26.4b1 at the time of inquiry. The U.S. FOIA (b)(6) confirmed the facility did not have a policy for updating ICCPs, only the "Care Plans - Baseline" policy that was provided. A review of the facility's undated "Care Plans - Baseline" policy did not include care plan revisions.	F 657		
F 658 SS=D	NJAC 8:39-27.1(a) 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 NJ #: 163699; 172074	F 658	1. How the corrective action will be	9/9/24

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F 658	Continued From page 14 Based on observation, interview, and review of facility documents, it was determined that the facility failed to follow professional standards of clinical practice with respect to a.)administering NJ Exec Order 26.4b1 medications as ordered for a resident with NJ Exec Order 26.4b1 (Resident #48); b.) increasing the dose of two medications for a resident with NJ Exec Order 26.4b1 in accordance with the physician's orders (Resident #225); c.) following a physician's order for NJ Ex Order 26.4b1 to a NJ Exec Order 26.4b1 site (Resident #68); and c.) following their Outbreak Plan and Isolation policy and procedures by not notifying emergency transport staff and receiving facility staff of a resident's NJ Ex Order 26.4b1 status upon the resident's (Resident #100) transfer to the Emergency Room (ER). This deficient practice was identified for 4 of 38 resident reviewed for professional standards of practice. 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." The surveyor reviewed the policy titled, "Administering Medications", the policy had a revision date of 10/2023. The policy statement indicated that medications shall be administered in a safe and timely manner and as prescribed. Number 2 of policy interpretation indicated that	F 658	accomplished for those residents found to have been affected by the deficient practice: A) Resident #48 was affected by the NJ Exec Order 26.4b1. Resident was NJ Exec Order 26.4b1 was addressed. PMD was made aware of missed medication and new orders given for a one-time dose and was administered. Resident was NJ Ex Order 26.4b1 Unit Manager performed an audit on all residents that received 6AM meds and no other resident was affected by the deficient practice. B) Resident # 225 was affected by the deficient practice. The resident was assessed, and NJ Ex Order 26.4b1 was noted from missed medication. The MD confirmed the medication order and resident was later medicated with NJ Ex C) Resident # 68 was affected by the NJ Exec Order 26.4b1. Resident was assessed by U.S. FOIA (b)(6) and NJ Exec Order 26.4b1 Resident had NJ Ex Order 26.4b1 and PMD was made aware. D) Resident #100 was affected by the deficient practice. The receiving facility was not adversely affected by the missed communication. 2. How the facility will identify other resident having the potential to be affected by the deficient practice: A) All residents who are receiving medication have the potential to be affected by the deficient practice.	

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F 658	Continued From page 15 medications must be administered in accordance with the orders, including any required timeframe. Number 9 indicated that if a drug is withheld, refused, or given at another time other than scheduled the individual administering the medication will document in the medication administration record. The was evidence was as follows: 1. On 8/21/24 at 9:21 AM, during the 9:00 AM medication pass for Resident #48, the resident asked the Licensed Practical Nurse (LPN #1) why they did not receive their 6:00 AM[NJ Exec Order 26.4b1] [redacted]. The nurse stated she was unsure and would investigate the issue. LPN #1 asked the resident what their [redacted] level was, and the resident responded, [redacted]. (On the numeric [redacted].) The surveyor then reviewed the narcotic book with LPN #1 for Resident #48 medications and the last [redacted] was signed out as removed from the cart on [redacted] at 12:00 PM. The surveyor then observed LPN #1 do an inventory count of the [redacted] tablets, and it was accurate with the [redacted] book meaning no pills were removed after the dose on [redacted] at 12:00 PM. On 8/21/24 at 10:10 AM, the surveyor reviewed the medical record for Resident #48. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses that included but were not limited to: [redacted]	F 658	B) All resident that are seen by the Psychiatrist have the potential to be affected by the deficient practice. C) All residents with wound care orders have the potential to be affected by the deficient practice. D) All residents who maybe transferred to another facility have the potential to be affected by the deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: A) The DON/ Designee reeducated the nurse on proper medication administration to include accurate documentation and pain management B) The DON/ Designee reeducated nursing staff on communication with Physician prior to carrying out psychiatric recommendation. The DON/ Designee reeducated all nurses on confirming all order on the shift to prevent missed medication. C) The DON/ Designee reeducated the US FOIA (b)(6) to update resident profile, care plan and Kardex to reflex any recommendation for wound treatment to include allergies. D) The DON/ Designee reeducated all nurses on completing universal transfer form to ensure proper communication, appropriate care and provide verbal report to accepting facility. 4. How the facility will monitor its corrective actions to ensure that the	

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F 658	Continued From page 16 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a brief interview for mental status (BIMS) score of a [redacted], which indicated a NJ Exec Order 26.4b1. A further review revealed the resident was on a scheduled NJ Exec Order 26.4b1. A review of the Medication Administration Record (MAR) revealed the [redacted] scheduled for NJ Exec Order 26.4b1, the nurse documented it was administered. A review of the Order Summary Report included a physician's order (PO) dated NJ Exec Order 26.4b1 [redacted]; to give [redacted] by [redacted] times a day for NJ Exec Order 26.4b1. A review of the individualized comprehensive care plan (ICCP) included the following focus areas: A focus area dated [redacted], that the resident used a NJ Exec Order 26.4b1 [redacted] with an intervention that included to NJ Ex Order 26.4b1 every shift. A focus area dated [redacted], that the resident had NJ Exec Order 26.4b1 [redacted]. Interventions included to administer [redacted] as per orders; give [redacted] before treatments or care; administer [redacted] per orders and notify the physician if goal was not met with regimen; anticipate the resident's need for [redacted] and respond immediately to any NJ Ex Order 26.4b1; and assess my medications and adjust as needed. On 8/22/24 at 11:00 AM, surveyor interviewed the U.S. FOIA (b)(6) [redacted]) regarding the	F 658	deficient practice will not recur. A) The DON or designee will audit 5 alert, oriented residents to ensure that they are receiving their medication in a timely manner and pain is controlled. B) The DON or designee will audit 5 resident charts after Psychiatrist or Physician visit to ensure all recommendations are carried out in a timely manner. C) The DON or designee will audit 5 resident charts with wounds, review recommended orders and assess resident to ensure orders are carried out accurately. D) The DON or designee will audit 5 residents who were transferred to another facility to ensure that universal transfer form was accurately completed to ensure proper communication. This audit will perform weekly x 4weeks and then monthly x 2 5. The results of the audit will be submitted and reviewed to the QAPI committee monthly/ quarterly to ensure that facility's corrective action for the deficient practice will not recur.	

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resident not receiving their NJ Ex Order 26.4b1 at 6:00 AM. The U.S. FOIA (b)(6) stated that the resident was sleeping, and the nurse did not want to wake them up, and the nurse "meant to" sign as not given but she "forgot". The U.S. FOIA (b)(6) stated that the facility was going to change the NJ Exec Order 26.4b1 scheduled time so the resident would not need to be woken up.

2. On 8/19/24 at 10:55 AM, during the initial tour of the facility, the surveyor observed Resident #225 in their room in bed. The resident informed the surveyor that the facility ran out of medications sometimes, "For one or two days and I don't get my medicine". The resident was not able to tell the surveyor which medications.

On 8/22/24 at 10:15 AM, the surveyor reviewed the medical record for Resident #225.

A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted]

A review of the most recent comprehensive Minimum Data Set (MDS) dated NJ Exec Order 26.4b that the resident had a BIMS score of NJ Exec Order 26.4b1, which meant a NJ Exec Order 26.4b1.

A review of the NJ Exec Order 26.4b1 MAR revealed that the resident had POs dated NJ Exec Order 26.4, for

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NJ Exec Order 26.4b1 ; give one tablet by mouth every bedtime for NJ Exec Order 26.4b1 and a PO dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 ; give two capsules by mouth every night at bedtime for NJ Exec Order 26.4b1 .

A review of the Order Summary Report revealed that the PO dated NJ Exec Order 26.4b1 tablets at bedtime was discontinued on NJ Exec Order 26.4b at 8:23 PM, and a new order for NJ Exec Order 26.4b1 at bedtime was ordered to start on NJ Exec Order 26.4 at 10:00 PM.

Further review of the physician orders revealed NJ Exec Order 26.4b1 by the physician from NJ Ex at bedtime on NJ Exec Order 26.4b1, with an order start time of NJ Exec Order 26.4b1

A review of the corresponding MAR revealed that the medications were not signed as administered by the nurse on NJ Exec Order 26.4b

On 8/22/24 at 11:11 AM, the surveyor interviewed Resident #225, who stated they did not get their medications last night like the physician ordered and stated, "I have NJ Exec Order 26.4b1 ".

On 8/22/24 at 12:20 PM, the surveyor reviewed the resident's ICCP which included a focus area dated NJ Ex Order 26, that the resident used NJ Exec Order 26.4b1 medications related to the disease process and had a NJ Exec Order 26.4b1 .

On 8/22/24 at 12:25 PM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the resident not receiving the medications, and the U.S. FOIA (b)(6) confirmed that the resident should have received the medications when the order was changed.

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F 658	Continued From page 19 On 8/22/24 at 12:33 PM, the surveyor conducted a telephone interview with the resident's Physician, who stated that the U.S. FOIA (b)(6) [redacted] made recommendations that they did not agree was best for the resident. The Physician stated that he decided to enter his own orders, which the surveyor confirmed he entered on NJ Exec Order 26.4b1. The Physician confirmed he wanted the new orders to start that evening. On 8/22/24 at 1:15 PM, the [redacted] revealed the nurse spoke to the Physician on NJ Exec Order 26.4b1 [redacted], and that the Physician told the nurse that he would be entering his own orders into the computer. The resident was notified of the Physician's decision at that time. On 8/27/24 at 9:50 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding Resident #225's medication change, and the U.S. FOIA (b)(6) stated that the supervisor spoke with the Physician and the Physician entered the order, but the order was not confirmed by the nurse until NJ Exec Order 26.4b1 [redacted]. The surveyor asked the U.S. FOIA (b)(6) if the nurse who was aware of the upcoming change should have followed up with the orders, and the U.S. FOIA (b)(6) confirmed yes. 3. On 8/19/24 at 11:18 AM, the surveyor observed Resident #68 sitting in their wheelchair in the dayroom during activities. At that time, the Resident's Representative (RR) who was with Resident #68, informed the surveyor that the facility's nurses did not communicate with each	F 658		

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other. The RR stated that they visited the resident daily, and a few times a week, they noticed NJ Ex Order 26.4b1 on the resident's NJ Exec Order 26.4b1 for their NJ Exec Order 26.4b1 (NJ Exec Order 26.4b1). The U.S. FO stated the resident could not use because it made their NJ Ex Orb out in a NJ Exec Or. The RR stated there was NJ Ex Order on the resident's NJ Ex Order 26.4b1 this morning when they arrived, and they had to remove it.

On 8/22/24 at 10:08 AM, the surveyor reviewed the medical record for Resident #68.

A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included NJ Exec Order 26.4b1 .

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2, reflected the resident had a brief interview for mental status (BIMS) score of a NJ Exec Order 26.4b1 , which indicated a NJ Exec Order 26.4b1 . A further review included the resident had NJ Ex Order 26.4b1 NJ Exec Order 26.4b1) which they received greater than NJ Ex Order 26.4b1 and over U.S. FOIA (b)(6)

A review of the Medication Review Report (MRR) included a physician's order (PO) dated NJ Exec Order 26., to cleanse the NJ Exec Order 26.4b1 and cover with a NJ Ex Order 26.4b1 daily. Do not use NJ Ex Order 26.4b1 .

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F 658	Continued From page 21 On 8/22/24 at 12:30 PM, the surveyor observed Resident #68 sitting in the dining room with the RR. At that time, the RR informed the surveyor that there was NJ Ex Order 26.4b1 on the resident's NJ Exec Order 26.4b1 and they pulled up the resident's shirt to show the surveyor. The surveyor asked if they could go back to the resident's room to show the nurse, and the RR stated yes. On 8/22/24 at 12:35 PM, the surveyor asked the Unit Manager/Licensed Practical Nurse (UM/LPN #1) to accompany them to the Resident #68's room and look if the resident had NJ Ex Order 26.4b1 on their NJ Exec Order 26.4b1. UM/LPN #1 with the resident's permission observed the resident's NJ Exec Order 26.4b1 and confirmed there was NJ Ex Order 26.4b1 and removed it. The NJ Exec O at that time stated that the NJ Exec Order 26.4b1 did not want NJ Ex Order 26.4b1 on the resident's NJ Exec Order 26.4b because it caused a NJ Exec Orde The NJ Exec stated that the US FO instructed that the NJ Ex Order 26 should have been wrapped around the NJ Ex Order 26.4b1 to the U.S. FOIA (b)(6) On 8/22/24 at 12:45 PM, UM/LPN #1 provided the surveyor with the NJ Ex Order 26.4b1 dated NJ Ex Order 26.4b, which she stated that the US FOIA (b)(6) only recommended "limit use of NJ Ex Order 26.4b1" and the US FOIA (b)(6) did not indicate NJ Ex Order 26.4b. The surveyor asked if the PO indicated NJ Ex Order 26.4b1, and UM/LPN #1 confirmed it did. The surveyor asked if the nurses were expected to follow the PO's as written, and UM/LPN #1 confirmed yes. On 8/22/24 at 1:03 PM, the surveyor interviewed Resident #68's nurse for the day, the Licensed Practical Nurse (LPN #2), who stated she was an Agency nurse, and it was NJ Ex Order 26.4b1 on the unit. LPN #2 stated when she arrived at the unit today,	F 658		

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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 658	Continued From page 22 she was informed the resident's treatment was done, and she observed the [NJ Ex Order 26.4b1] looked clean, so she did not touch it. LPN #2 stated she was unaware the [NJ Ex Order 26.4b1] should not have [NJ Ex Order 26.4b1] until someone brought it to her attention when the RR informed them. On 8/22/24 at 1:15 PM, the surveyor continued to review the medical record. A review of the Progress Notes included a [U.S. FOIA (b)(6)] note dated [NJ Ex Order 26.4b] at 1:00 PM, which the [U.S. FO] noted that the resident's [NJ Exec Or] at their [NJ Exec Order 26] site was [NJ Exec Order 26.4b1] from the [NJ Ex Order 26.4b1]. The [U.S. FOIA] ordered to not use [NJ Ex Order 26.4b1]. On 8/22/24 at 1:52 PM, the surveyor interviewed the [redacted] who stated nurses were expected to carry out a physician's order as written. The [U.S. FOIA (b)(6)] confirmed the nurse should not have used [NJ Ex Order 26.4b1] on the resident's [NJ Exec Order2] site. A review of the facility's "Administering Medications" policy dated updated October 2023, included medications must be administer in accordance with orders, including the required timeframe...if a drug is withheld, refused, or given at another time other than the scheduled time, the individual administering the medication will document in medication administration record... 4. A review of the facility provided, "Policy for Emergent Infectious Diseases [EID] (COVID-19) Outbreak Plan V10" dated updated 1/1/24, included but was not limited to; Goal: to protect residents, families, and staff from...exposure to	F 658		

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	315015	A. BUILDING _____ B. WING _____	C 08/27/2024

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F 658	Continued From page 23 an emergent infectious disease while they are in our care center. 2. Local Threat: ... d. staff will be educated on the exposure risks, symptoms, and prevention of the EID... 3. Suspected case in the care facility: g. implements the isolation protocol...please refer to (Isolation-Categories of Transmission-Based Precautions). A review of the facility provided policy, "Isolation-Categories of Transmission-Based Precautions" revised/reviewed 1/2024, included but was not limited to; Policy Interpretation and Implementation: "1. Transmission-based Precautions will be used whenever measure more stringent than Standard Precautions are needed to prevent or control the spread of infection." Contact Precautions: "6 Resident Transport b. If the resident is transported ... to another facility, the Infection Preventionist (or designee) will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions." Droplet Precautions: "5 Resident Transport c. If the resident is transported... to another facility, the Infection Preventionist (or designee) will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions." On 8/26/24 at 10:38 AM, the [US FOIA (b)(6)] [redacted] reviewed the facility's Line Listing (LL) with the surveyor. The [US FOIA (b)(6)] [redacted] revealed that residents who were COVID-19	F 658		

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F 658	Continued From page 24 positive would be noted on the LL and that contact tracing would be performed to evaluate if additional residents, staff, or visitors may have been exposed to COVID-19. Upon reviewing the provided information, the surveyor noted that Resident #100 had [redacted], and was the only resident listed as having had gone to the hospital with the comments documented, "not [redacted] related". A review of the electronic Progress Notes (PN) included the following: A PN dated [redacted] at 9:35 AM, documented that Resident #100 was NJ Exec Order 26.4b1 [redacted] to [name redacted] hospital. On the same date at 5:30 PM, that the resident returned from the hospital and was [redacted] A PN dated [redacted] at 10:18 AM, documented that Resident #100 was NJ Exec Order 26.4b1 [redacted] On the same date at 11:18 AM, the resident was transported to [name redacted] hospital for evaluation. The resident was transported by two transporters at 12:20 PM. Resident #100 was admitted to the hospital. The next PN in the medical record was dated NJ Exec Order 26.4b1, when the resident was readmitted to the facility. There was no evidence in the PN's that the facility informed the medical transporters or receiving hospital that Resident #100 required	F 658		

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F 658	Continued From page 25 NJ Ex Order 26.4b1 . A review of the New Jersey Universal Transfer Form dated NJ Ex Order 26.4b, item #12 isolation/precaution was left blank. Item #19 Attached Documents which included items such as physicians orders, was left blank. A review of Resident #100's medical record Admission Record printed 8/27/24, revealed the resident had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 . The list of diagnoses failed to include NJ Exec Order 26.4b1 onset date of NJ Exec Order 26.4. A review of the most recent quarterly MDS dated NJ Exec Order 26.4b reflected the resident had a BIMS score of NJ Exec Order 26.4b1, indicating Resident #100 had NJ Exec Order 26.4b1 . A review of the Order Summary Report revealed an order dated NJ Exec Order 26.4, that the resident was on NJ Ex Order 26.4b1 [...] for diagnosis NJ Exec Order 26.4b1 . A review of the ICCP included a focus area that the resident required NJ Ex Order 26.4b1 specifically related to NJ Ex Order 26.4b1 with interventions which included to educate staff, resident, family and visitors of NJ Ex Order 26.4b1 signs and symptoms and precautions. On 8/26/24 at 11:13 AM, the surveyor interviewed the US FOIA (b)(6) who stated if a resident was going to the hospital, that the staff filled out the Universal Transfer Form and wrote isolation precautions on the form. The US FOIA (b)(6) also stated that the staff called the hospital with a report, and they "verbally" informed the transport staff. The	F 658		

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F 658	Continued From page 26 US FOIA (b)(6) confirmed it was important to document in case the receiving staff did not get to the resident right away in the hospital. On 8/27/24 at 10:57 AM, the surveyor asked the U.S. FOIA (b)(6) in the presence of the survey team, about informing the transporters and receiving hospital regarding Resident #100 being NJ Ex Order 26.4b1. The U.S. FOIA (b)(6) stated if it was not documented that it was reported to transport and the hospital staff that the resident was NJ Ex Order 26.4b1, it was not done. She further stated NJ Ex Order 26.4b1 results should be documented on the New Jersey Universal Transfer Form to ensure whoever receives the resident was aware. The U.S. FOIA (b)(6) stated that if the NJ Ex Order 26.4b1 status was not conveyed, it could spread the infection. On 8/27/24 at 11:21 AM, the U.S. FOIA (b)(6) stated that the NJ Ex Order 26.4b1 precautions were on the physician's orders, but she could not provide any documentation that transport or anyone at the receiving hospital was made aware that Resident #100 was NJ Ex Order 26.4b1. No additional information was provided. NJAC 8:39-11.2, 27.1, 29.2	F 658		
F 755 SS=E	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	F 755		9/18/24

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F 755	Continued From page 27 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide 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: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure the narcotic count was completed on multiple days and shifts for August 2024 for 3 of 3 medication carts reviewed; b.) ensure accurate accountability for individual controlled medications for 3 of 3 medication carts reviewed; and c.) ensure the required Federal narcotic acquisition forms (DEA 222 forms) were dated and signed by the Medical Director as of the day it was submitted for filling for 1 of 1 forms provided. The deficient practice	F 755	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. A) All the units were affected by the deficient practice. All narcotic sheets were reviewed immediately, and Nurses were educated on completing narcotic sheets on their assigned shifts B) Residents #275, #62, # 45, #70, and #28 were affected by the [NJ Exec Order 26.4b] [redacted]. The narcotic inventory declining	

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F 755	Continued From page 28 was evidenced by the following: 1. During medication storage review on 8/26/24 at 9:55 AM, the surveyor in the presence of the U.S. FOIA (b)(6) reviewed the NJ E Wing nursing unit's Medication Cart #2's August 2024 NJ Exec Order 26.4b1 Sign-in Sheet" (shift-to-shift accountability count sheet for controlled substance and narcotics (narc) signed by the incoming and outgoing nurses each shift) which revealed the following: The narcotic counts were blank for the incoming nurse "Total # of Narcs" for the following shifts: All shifts on: 8/1; 8/2; 8/5; 8/10; 8/13; 8/15; 8/16; 8/17; 8/18; and 8/23. For the day shift (7:00 AM to 3:00 PM) on: 8/3; 8/4; 8/6; 8/7; 8/11; 8/12; 8/14; and 8/26. For the evening shift (3:00 PM to 11:00 PM) on: 8/3; 8/6; 8/7; 8/8; 8/12; 8/14; 8/24; and 8/25. For the overnight shift (11:00 PM to 7:00 AM) on: 8/11; 8/12; 8/19; 8/20; 8/21; 8/22; 8/24; and 8/25. The narcotic counts were left blank for the outgoing "Total # of Narcs" for the following shifts: All shifts on: 8/1; 8/2; 8/5; 8/10; 8/13; 8/14; 8/15; 8/16; 8/17; 8/18; and 8/23. For the day shift on: 8/3; 8/4; 8/6; 8/7; 8/9; 8/11; 8/12; 8/20; and 8/26. For the evening shift on: 8/3; 8/6; 8/7; 8/8; 8/12; 8/22; 8/24; and 8/25. For the overnight shift on: 8/9; 8/11; 8/19; 8/21; 8/22; 8/24; and 8/25. Nursing signatures were missing for Incoming Nurse evening shift on 8/9 and Outgoing Nurse for 8/22 evening shift.	F 755	sheet was reviewed, and nurses were reeducated on signing narcotic sheet on their assigned shift. C) DON immediately voided controlled substance form 222 that was pre-signed. DON reordered new DEA form 222. 2. How the facility will identify other residents having the potential to be affected by the deficient practice. All resident with narcotic medication have the potential to be affected by the deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: A) The DON/ Designee reeducated all nurses regarding timely manner signing narcotic sheets. B) The DON/ Designee reeducated the US FOIA (b)(6) to ensure that all nurses are accurately documenting narcotic medication administration and are signing on narcotic declining inventory sheets . c) The Regional Nurse educated the US FOIA (b) that DEA form 222 must not be pre signed. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. A) The DON or designee will audit 2 medication carts weekly x 4 then monthly x 2, to ensure that narcotic inventory sheet are signed timely and accurately. b) The DON or designee will audit weekly x 4 then monthly x 2, five (5) resident	

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F 755	Continued From page 29 A further review of the "Individual Patient Controlled Substance Administration Record" (declining inventory sheet; declining inventory log used to document individual resident-controlled substance administration) revealed the following: Resident #275's declining inventory sheet for NJ Exec Order 26.4b1, the nurse did not sign the dose for NJ Exec Order 26.4b1 Resident #62's declining inventory sheet for NJ Exec Order 26.4b1 the nurse did not sign the dose for NJ Ex Order 26.4b at 9:00 PM and NJ Ex Order 26.4b at 10:00 PM. At that time, the U.S. FO confirmed that the narcotic shift-to-shift log and the declining inventory sheets were missing nurses' signatures and there should not be. On 8/26/24 at 10:37 AM, the surveyor in the presence of the U.S. FOIA (b)(6), reviewed the U.S. F Wing nursing unit's Medication Cart #1's August 2024 "Narcotic and Controlled Drug Sign-in Sheet" which revealed the following: The narcotic counts were blank for the incoming nurse "Total # of Narcs" for the following shifts: All shifts on: 8/1; 8/2; 8/3; 8/4; 8/5; 8/6; 8/7; 8/8; 8/9; 8/10; 8/11; 8/12; 8/13; 8/14; 8/15; 8/16; 8/17; 8/18; 8/19; 8/20; 8/22; 8/23; and 8/25. For the day shift on: 8/24 and 8/26. For the evening shift on: 8/21. For the overnight shift on: 8/21.	F 755	charts that are on narcotic medication to ensure that the narcotic inventory declining sheet is accurately completed. c) The Regional Nurse will audit one (1)DEA Form 222 weekly x 4 weeks then Monthly x2 months to ensure that they are not pre-signed by Medical Director. 5. The results of the audit will be submitted and reviewed to the QAPI committee quarterly to ensure that facility□s corrective action for the deficient practice will not recur. the QAPI committee meets Quarterly.	

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F 755	Continued From page 30 The narcotic counts were left blank for the outgoing "Total # of Narcs" for the following shifts: All shifts on: 8/1; 8/2; 8/3; 8/4; 8/5; 8/6; 8/7; 8/8; 8/9; 8/10; 8/11; 8/12; 8/13; 8/14; 8/15; 8/16; 8/17; 8/18; 8/19; 8/20; 8/22; 8/23; and 8/25. For the day shift on: 8/24. For the evening shift on: 8/21. For the overnight shift on: 8/21 and 8/24. Nursing signatures were missing for 8/25 Incoming Nurse evening and Outgoing Nurse evening shift. Further review of the "Individual Patient Controlled Substance Administration Record" revealed the following: Resident #46's declining inventory sheet for [redacted] was missing the date, time, and "Nurse Administering" signature for the fourth dose administered with a remaining balance of [redacted]. At that time, the [redacted] acknowledged that there should be no missing signatures or documentation on any of the narcotic logs. On 8/26/24 at 11:11 AM, the surveyor in the presence of the [redacted], reviewed the [redacted] Wing" nursing unit's Medication Cart #1's August 2024 "Narcotic and Controlled Drug Sign-in Sheet" which revealed the following: The narcotic counts were blank for the "# of count sheets" for the following shifts: For the day shift on: 8/12; and 8/25.	F 755		

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F 755	Continued From page 31	F 755		

For the evening shift on: 8/5; 8/11; and 8/25.
For the overnight shift on: 8/1; 8/2; 8/4; 8/5; 8/8; 8/10; 8/11; 8/12; 8/15; 8/21; 8/24; and 8/25.

The column labeled "is count correct?" was blank on the following shifts:

For the evening shift on: 8/25.
For the overnight shift on: 8/5; 8/9; 8/15; 8/22; and 8/23.

"Nurse's Signature Going off Duty" was blank for 8/24 day shift and pre-signed for 8/26 evening shift.

Further review of the "Individual Patient Controlled Substance Administration Record" revealed the following:

Resident #11 declining inventory sheet for [redacted] was missing the "Nurse Administering" signature for the dose administered on [redacted] at 9:00 AM, and the [redacted] at 10:00 AM dose the [redacted] administered.

Resident #70's declining inventory sheet for [redacted] was not signed by the [redacted] for the dose administered on [redacted] at 9:00 AM.

Resident #28's declining inventory sheet for [redacted] was not signed by the [redacted] for the dose administered on [redacted] at 9:00 AM.

At that time, the [redacted] acknowledged that there should be no missing documentation on the narcotic logs. The [redacted] stated that she did not

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F 755	Continued From page 32 sign the individual declining inventory sheets that morning because she "got busy, and I would come back to them." The [NJ Exec Onl] also acknowledged that she had pre-signed the shift-to-shift count log for the end of her shift, and that was not the appropriate protocol. The [NJ Exec Onl] confirmed that the incoming and the outgoing nurses were to complete the count and sign together at the end of each shift. On 8/26/24 at 12:22 PM, the surveyor interviewed the [U.S. FOIA (b)(6)]), who stated that the narcotic count for each medication cart was to be completed at each shift hand off by the incoming and the outgoing nurses. The [U.S. FOIA (b)(6)] confirmed that there should be no missing documentation on narcotic logs, and there should also be no pre-signed fields, and the if it was not documented, it was considered not done. The [U.S. FOIA (b)(6)] further stated that declining inventory logs were to be completed by the administering nurse for each dose at the time the medication was dispensed to keep accountability of the narcotics administered. 2. On 8/27/24 at 10:11 AM, the surveyor in the presence of the [U.S. FOIA (b)(6)] and the survey team, reviewed the facility provided DEA 222 forms which revealed that order form number [redacted] had been pre-signed by the facility's [U.S. FOIA (b)(6)] prior to submission to the provider pharmacy for filling. At that time, the [U.S. FOIA (b)(6)] confirmed that the DEA 222 form should not have been pre-signed by the physician.	F 755		

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F 755	Continued From page 33 The facility was unable to provide a policy regarding the completion of the DEA 222 form. A review of the facility's "Controlled Substances" policy dated updated April 2024, included...nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services... The policy did not include resident's declining inventory sheets.	F 755		
F 761 SS=D	NJAC 8:39-29.7(c) 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 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	F 761		9/9/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MADISON, LLC	**625 STATE HIGHWAY 34 MATAWAN, NJ 07747**

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F 761	Continued From page 34 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 properly store medication. This deficient practice was identified in 3 of 3 medication carts inspected, and was evidenced by the following: On 8/26/24 at 9:55 AM, the surveyor, in the presence of the U.S. FOIA (b)(6) inspected the [redacted]-Wing nursing unit's Medication Cart #2 and observed two unidentifiable, loose medication pills of varying shapes, color, and size in the bottom of the drawer containing the medication blister packages. At that time, the RN confirmed that there should be no loose pills in the medication cart, and that the nurses assigned to the cart were responsible for maintaining the organization and cleanliness of the cart and its contents. On 8/26/24 at 10:37 AM, the surveyor, in the presence of the U.S. FOIA (b)(6) [redacted] inspected the [redacted] Wing nursing unit's Medication Cart #1 and observed nineteen unidentifiable, loose medication pills of various colors, shapes, and sizes in the bottom of the drawer containing the medication blister packages. At that time, the U.S. FOIA (b)(6) confirmed that there	F 761	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All units with medication carts were affected. The Unit Managers and the assigned nurse assigned to each cart immediately cleaned the Medication carts. 2. How the facility will identify other residents having the potential to be affected by the deficient practice. All Units with medication carts have the potential to be affected by the deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: DON/designee reeducated all nurses on the cleaning of the medication cart to avoid presence of loose pills in the carts. All medication carts will be inspected biweekly by Unit manager/designee to ensure compliance with cleaning. 4.How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The DON or designee will audit 3 medication carts for loose pills weekly x4 and then monthly x 2. The results of the audit will be submitted and reviewed to the QAPI committee monthly/ quarterly to	

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F 761	Continued From page 35 should never be any loose pills in the medication cart, and that the nurses assigned to the cart were responsible for maintaining the organization and cleanliness of the cart and its contents. On 8/26/24 at 11:11 AM, the surveyor, in the presence of the U.S. FOIA (b)(6) inspected the Wing nursing unit's Medication Cart #1 and observed six unidentifiable, loose medication pills of various colors, shapes, and sizes in the bottom of the drawer containing the medication blister packages. At that time, the confirmed that there should never be any loose pills in the medication cart, and that the nurses assigned to the cart were responsible for maintaining the organization and cleanliness of the cart and its contents. On 8/26/24 at 12:22 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated all medications should be stored in the packaging in which it was received, and that there should be no loose pills in the medication carts. A review of the facility's "Medication Storage" policy dated reviewed January 2024, included the facility shall store all medication and biologicals in a safe, secure, and orderly manner...medications and biologicals shall be stored in the packaging, containers, or other dispensing system in which they are received... NJAC 8:39-29.4	F 761	ensure that facility's corrective action for the deficient practice will not recur.	
F 770 SS=E	Laboratory Services CFR(s): 483.50(a)(1)(i)	F 770		9/9/24

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F 770	Continued From page 36 §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. 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 ensure NJ Exec Order 26.4b1 recommendations from NJ Ex Order 26 and NJ Ex Order 26.4b, to check NJ Exec Order 26.4b1 of medication used to trea NJ Exec Order 26 r, were obtained in a timely manner. The deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #68), and was evidenced by the following: On 8/19/24 at 11:18 AM, the surveyor observed Resident #68 sitting in the dayroom during activities. They were NJ Ex Order 26.4b1 interviewed. On 8/22/24 at 10:08 AM, the surveyor reviewed the medical record for Resident #68. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included NJ Exec Order 26.4b1 [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated	F 770	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 68 was affected by the NJ Exec Order 26.4b1. The Lab was ordered NJ Ex Order 26.4b1 [redacted]. 2. How the facility will identify other residents having the potential to be affected by the deficient practice. All residents with laboratory orders have the potential to be affected by the deficient practice, all residents on psychotropic drugs were audited for any missed labs. No missing lab orders were found. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: The DON/Designee reeducated all nurses to carry out physician order in a timely manner. The DON/Designee will reeducate the unit manager to ensure that	

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F 770	Continued From page 37 NJ Ex Order 26, reflected the resident had a brief interview for mental status (BIMS) score of a NJ Exec Order 26.4b1 which indicated a NJ Exec Order 26.4b1. A further review included the resident took NJ Exec Order 26.4b1 medications daily. A review of the Medication Review Report included a physician's order dated NJ Exec Order 26.4b for NJ Exec Order 26.4b1; give NJ Exec O A review of the individualize comprehensive care Plan (ICCP) included a focus area dated NJ Ex Order 26.4b1, that the resident used NJ Exec Order 26.4b1 medication NJ Exec Order 26.4b1 with regards NJ Ex Order 26.4b1. Interventions included to administer medications as ordered. A review of the U.S. FOIA (b)(6) Progress Note dated NJ Ex Order 26, included for the plan to repeat lithium level NJ Exec Order 26.4b1). A review of the corresponding lab reports revealed that the were not tested until NJ Ex Order 26.4b. A review of the Progress Notes from NJ Ex Order 26 until the labs were completed on NJ Ex Order 26.4b, did not include a note for the delay in labs. A review of the NJ Exec Order 26.4b1 Progress Note dated NJ Exec Order 26.4, included for the plan to check NJ Exec Order 26 NJ Exec Order. A review of the corresponding lab reports did not	F 770	new orders by physician are carried out in a timely manner. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The DON/Designee will audit 5 resident records to ensure all Physician orders are carried out in a timely manner. This will be done weekly x 4 weeks then monthly x 2. The results of the audit will be submitted and reviewed to the QAPI committee monthly/ quarterly to ensure that facility's corrective action for the deficient practice will not recur.	

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F 770	Continued From page 38 include a [redacted] was completed. A review of the Progress Notes included a Nurse's Note dated [redacted], that resident was seen by [redacted] at beside with [redacted] present with a new recommendation to increase [redacted] The note did not include to check the [redacted] On 8/22/24 at 12:48 PM, the surveyor interviewed the [redacted], who stated after a resident was seen by [redacted], the nurse reviewed the consultation (consult), and if there were any new recommendations, the nurse called the resident's physician to tell them. The [redacted] stated the physician was notified right away, and the nurse documented it. The [redacted] stated if labs were recommended, the labs were usually ordered for the next day. The [redacted] confirmed Resident #68 took [redacted], and the physician ordered labs for the [redacted] she thought quarterly, but the labs were completed when ordered. At that time the surveyor reviewed with the [redacted] the resident's [redacted] Progress Notes from [redacted] which both recommended to check [redacted]. The [redacted] confirmed the only labs in the electronic medical record were from [redacted], but she stated she would check to see if any labs were done and not in the electronic medical record. On 8/22/24 1:23 PM, the surveyor re-interviewed the [redacted] confirmed the only lab report for the [redacted] level being checked was from [redacted]. The [redacted] stated that she had to call the physician to see if they wanted the resident's [redacted] checked, that it was usually done	F 770		

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F 770	Continued From page 39 quarterly. On 8/22/24 at 1:52 PM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated after a resident had a consult, the nurse reviewed the consult with the resident's physician as soon as possible, and documented in the Progress Notes if the physician agreed or disagreed with the recommendation. At that time the surveyor with the U.S. FOIA (b)(6) reviewed Resident #68's NJ Exec Order 26.4b1 Progress Notes from NJ Exec Order 26.4b1 , and the U.S. FOIA (b) confirmed the physician should have been notified immediately. On 8/27/24 at 9:50 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6)) and survey team, acknowledged that there was no documentation that the nurses notified the physician after the resident's consults, and that the physician either agreed of disagreed with the recommendation to check the NJ Exec Order 26.4b1 . The U.S. FOIA (b)(6) confirmed the only labs for NJ Exec Order 26.4b1 that were performed this year was on NJ Exec Order 26.4 . A review of the facility's "Laboratory Services and Reporting" policy dated revised April 2024, included the facility must provide or obtain laboratory services to meet the needs of the residents; the facility is responsible for the timeliness of the services... A review of the facility's "Physician Orders" policy dated revised December 2023, included Consultant Recommendations/Orders:..in all cases, the attending physician must be notified of the order and approve per state regulation; findings and recommendations will be documented on the Consultation Form; the nurse	F 770		

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F 770	Continued From page 40 will notify the physician of findings and recommendations; the attending physician, if in agreement, will order the specific treatments as outlined by the consultant.	F 770		
F 825 SS=D	NJAC 8:39-27.1(a) Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 172074 Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to provide NJ Ex Order 26.4b1 services to a resident in a timely manner. This deficient practice was identified for 1 of 1 resident	F 825	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #226 was affected by the NJ Exec Order 26.4b1. NJ Ex Order 26.4b1 was immediately performed on the resident.	9/9/24

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F 825	Continued From page 41 reviewed for [NJ Ex Order 26.4b1] (Resident #226), and was evidenced by the following: On 8/19/24 at 11:04 AM, during the initial tour of the facility, the surveyor observed Resident #226 in their room in bed. The surveyor asked the resident if they were receiving speech, physical, or occupational therapy and the resident stated [NJ Ex Order 26.4b1]. On 8/19/24 at 1:00 PM, the surveyor reviewed the medical record for Resident #226. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to:[NJ Exec Order 26.4b1]). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated[NJ Exec Order 26], reflected the resident had a brief interview for mental status (BIMS) score[NJ Exec Order 26.4b1], which indicated a[NJ Exec Order 26.4b1]. A further review revealed that the resident had[NJ Exec Order 26.4b1] . A review of the Order Summary Report included the following physician's orders (PO) dated[NJ Exec Order 26.4], for[U.S. FOIA (b)(6)]) evaluation and treatment as recommended. A	F 825	2. How the facility will identify other residents having the potential to be affected by the deficient practice. All residents who have physician order for specialized rehab service has the potential to be affected by the deficient practice. An audit was done with no other resident affected by the deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: The DON/ Designee reeducated the[US FOIA (b)(6)] to review all specialty rehab services order to ensure all recommended services are completed in a timely manner. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The DON/ Designee will audit 1 new admission or readmission to ensure all specialized rehab orders are carried out in a timely manner. These audits will be performed weekly x 4 and then monthly x 2. The results of the audit will be submitted and reviewed to the QAPI committee quarterly to ensure that facility□s corrective action for the deficient practice will not recur. the QAPI committee meets quarterly.	

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F 825	Continued From page 42 further review included a PO dated [NJ Exec Order 26.4b] for [NJ Exec Order 26.4b1] precautions (practices that help [NJ Exec Order 26.4b1]) every shift. On 8/20/24 at 12:03 PM, the surveyor reviewed the therapy schedule from [NJ Exec] wing which included names and times of all therapies for the unit residents. Resident #226 [NJ Ex Order 26.4b1] [NJ Exec Order 26.4b] schedule. On 8/20/24 at 12:07 PM, the surveyor interviewed the [U.S. FOIA (b)(6)]), who stated she was a [U.S. FOIA] The [U.S. FOIA] stated that the resident did not receive [NJ Exec Order 26.4b1] yet because the family wanted to wait to get the resident a "[NJ Exec Order 26.4b1]". On 8/22/24 at 10:58 AM, the surveyor reviewed Resident #226's physician's orders which included the PO dated [NJ Exec Order 26.4], for the [U.S. FO] evaluation. The surveyor asked the [U.S. FOIA (b)] why the resident did not receive the ordered [U.S. FO] evaluation, and the [U.S. FOIA (b)] responded that she needed to check if it was completed. On 8/22/24 at 11:03 AM, the [U.S. FOIA] informed the surveyor that the [U.S. FO] evaluation was missed, and she would complete the evaluation on the resident at lunch today. The [U.S. FOIA] could not speak to why the evaluation was not done at the time ordered, and the surveyor asked if the evaluation should have been a priority since the resident had [NJ Ex Order 26.4b1] and the [U.S. FOIA (b)] responded, yes. The surveyor asked the [US FOIA (b)] what the facility's process was for receiving new therapy orders, and the [U.S. FOIA] stated that the nurse informed her in morning meeting, and the nurse probably did not	F 825		

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F 825	Continued From page 43 inform her of Resident #226's [U.S. FO] evaluation order. On 8/26/24 at 1:05 PM, the surveyor informed the U.S. FOIA (b)(6) and the [redacted]), in the presence of the survey team, their concern. The U.S. FOIA (b)(6) acknowledged that the resident was received a [U.S. FOIA] evaluation after surveyor inquiry. A review of the facility's "Tender Touch" policy dated revised February 2020, included evaluations may be performed by licensed Physical, Occupational, and Speech therapists. Evaluations should be initiated within 24 hours of the order and completed within 48 hours as feasible... NJAC 8:39-37.1	F 825		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that the resident call bell system functioned by: a.) ensuring call bell light illuminated outside of the resident's room when pushed; b.) call bell system	F 919	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents in room [NJ Exec] ([NJ Exec Order2]), room [NJ Exec]	9/20/24

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F 919	Continued From page 44 volume was set to a level to be heard; and c.) the call bell system accurately identified the room in need of assistance. This deficient practice was identified for 3 of 10 call bell lights tested and was evidenced by the following: On 8/21/24 at 1:45 PM, the surveyor in the presence of the [redacted] observed that Resident Room [redacted] (door) call bell light did not illuminate outside of the resident's room when tested by the [redacted]. The call bell system identified the room incorrectly as [redacted], and there was no audible notification at the nurse's station call bell system. On 8/21/24 1:46 PM, the surveyor in the presence of the [redacted] observed that Resident Room [redacted] (window) call bell did not illuminate outside of the resident's room and did not register a signal at the nurse's station call bell system when tested by the [redacted]. On 8/21/24 at 1:48 PM, the surveyor in the presence of the [redacted], observed that Resident Room [redacted] (door) call bell did not illuminate outside of the resident's room and there was no audible notification at the nurse's station call bell system when tested by the [redacted] On 8/21/24 at 1:49 PM, the surveyor in the presence of the [redacted], observed that Resident Room [redacted] (window) call bell did not illuminate outside of the resident's room and there was no audible notification at the nurse's station call bell system when tested by the [redacted] On 8/21/24 at 2:00 PM, the surveyor in the presence of the [redacted], observed that Resident Room [redacted] call bell did illuminate outside of the	F 919	([redacted] were affected by the deficient practice. The Administrator raised the volume on the call light system so the notification can be heard. Call bell system vendor was called immediately to update the call bell system in the computer and completed the work on 8/22/24. The residents affected were given tap bells. 2. How the facility will identify other residents having the potential to be affected, by the deficient practice. All residents with call bell system in the room have the potential to be affected by the deficient practice. An audit was completed on all resident rooms and no other resident was affected by the deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: The DON/ Designee reeducated the [redacted] and all staff to ensure all call bell systems should be illuminated outside of the room when activated, the volume should be audible, and staff can identify the room for quick response. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. Administrator/ designee will conduct and audit on 10 resident room to ensure that call bell system is functioning correctly to include that call bell is illuminated outside of the room when activated, the volume is audible, and the staff can identify the	

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COMPLETE CARE AT MADISON, LLC	**625 STATE HIGHWAY 34 MATAWAN, NJ 07747**

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F 919	Continued From page 45 resident's room and was properly identified at the nurse's station call bell system when tested by the [redacted] but there was no audible notification. Interview at the time of the observations, revealed that the [redacted] confirmed that there was no audible notification. Upon further investigation of the call bell system, the [redacted] discovered that the audible notification volume was turned all the way down on the call bell system and proceeded to raise the volume so that audible notification could be heard. On 8/22/24 at 11:10 AM, the surveyor interviewed the facility's Resident Call Bell System Vendor (RCBSV), who stated that they were in the process of updating the call bell system on the computer. The RCBSV stated that the updates were to correct the room identification displayed at the nurse's station, and they would stay and verify that the system was working properly before they left. The [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 8/22/24. NJAC 8:39-31.2(e); 31.8(c)9	F 919	room for quick response. These will be done weekly x 4 weeks and then monthly x 2. The results of the audit will be submitted and reviewed to the QAPI committee monthly/ quarterly to ensure that facility□s corrective action for the deficient practice will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061217	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MADISON, LLC	625 STATE HIGHWAY 34 MATAWAN, NJ 07747

(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: Complaint NJ #:16399; 172747 Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 19 of 28 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "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,	S 560	1. No resident identified was affected by the deficient practice. 2. All residents that reside in the facility have the potential to be affected by the deficient practice. 3. The DON/ Designee reeducated staffing coordinator on the required staffing ratio. DON/designee educated nursing staff and nurse coordinator on call out policy. Bonuses are offered to staff for open shift. Facility utilized outside staffing agency to fill out open shift. An open house for employment has been conducted for all positions open. The use of multiple search engine and platform are used to recruit staff. Advertisement signs for open nursing positions are placed in	9/16/24

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

Electronically Signed — 09/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061217	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: 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. During entrance conference on 8/19/24 at 10:04 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Acting Director of Nursing Acting (DON) how the facility's staff was, and the LNHA stated that staffing was good; that the facility used Agency staff as needed. At that time, the surveyor requested the Nurse Staffing Report to be completed for the following weeks: 1/7/24 to 1/13/24; 4/7/24 to 4/13/24; and 8/4/24 to 8/17/24. The surveyor reviewed the facility completed Nurse Staffing Reports which revealed the following: 1. For the week of Complaint staffing from 1/7/24 to 1/13/24, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:	S 560	front of the facility building. Staffing needs for the facility are assessed daily and if necessary, nursing managers (Unit Managers, ADON and IP) assists with resident care. 4. The DON or designee will conduct weekly CNA staffing schedule audit for 2 days of staffing, the reports of the finding will be presented to the administrator. Audits will be conducted weekly x 4 weeks then monthly x 2 months. The Administrator will analyze, trend and report the outcomes to the QAPI committee. the QAPI committee meets quarterly.	

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S 560	Continued From page 2 1/7/24 had 12 CNAs for 151 residents on the day shift, required at least 19 CNAs. 1/8/24 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs. 1/9/24 had 14 CNAs for 150 residents on the day shift, required at least 19 CNAs. 1/10/24 had 14 CNAs for 150 residents on the day shift, required at least 19 CNAs. 1/11/24 had 17 CNAs for 150 residents on the day shift, required at least 19 CNAs. 1/12/24 had 14 CNAs for 150 residents on the day shift, required at least 19 CNAs. 1/13/24 had 12 CNAs for 154 residents on the day shift, required at least 19 CNAs. 2. For the week of Complaint staffing from 4/7/24 to 4/13/24, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: 4/7/24 had 13 CNAs for 140 residents on the day shift, required at least 17 CNAs. 4/8/24 had 13 CNAs for 139 residents on the day shift, required at least 17 CNAs. 4/10/24 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. 4/11/24 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. 4/12/24 had 10 CNAs for 138 residents on the day shift, required at least 17 CNAs. 4/13/24 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs. 3. For the two weeks of staffing prior to survey from 8/4/24 to 8/17/24, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: 8/4/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs.	S 560		

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S 560	Continued From page 3 8/5/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. 8/6/24 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. 8/7/24 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. 8/8/24 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. 8/9/24 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs.	S 560		
S1690	8:39-25.2(d) Mandatory Nurse Staffing (d) In facilities with 150 licensed beds or more, there shall be an assistant director of nursing who is a registered professional nurse. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure there was an assistant director of nursing who was a registered professional nurse. This deficient practice was identified and evidence by the following: During entrance conference on 8/19/24 at 10:04 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and the Acting Director of Nursing Acting (DON) how many licensed beds the facility had. The LNHA stated the facility had 167 beds with a resident census of 118.	S1690	1. No resident was affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. The regional nurse reeducated the administrator of the states regular for facilities with census or licensed bed capacity of 150 or more shall have an ADON who is a Registered Nurse. A RN ADON has been hired as of [redacted] 4. . The Administrator or designee will Audit placement of Assistant Director of Nursing position being filled monthly x 3 months. outcomes to be reported to the QAPI	9/20/24

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S1690	Continued From page 4 On 8/26/24 at 8:58 AM, the surveyor interviewed the Infection Preventionist/Licensed Practical Nurse (IP/LPN) in the presence of the LNHA and Acting DON, who stated she was the former Assistant Director of Nursing (ADON) until she became the IP. The IP/LPN confirmed she was a LPN and not a registered nurse (RN). At that time, the LNHA stated that the IP/LPN was the ADON until she became the IP in NJ Ex Order 26.4b1 [redacted] The LNHA stated that the IP/LPN was the last ADON the facility had since the facility's census had been low, there had not been an ADON allocated. The LNHA stated the facility's average daily census was 120, so there was no "official" ADON. On 8/26/24 at 11:22 AM, the LNHA stated that the current DON, who was out of the building, was hired in NJ Exec Order 26.4b1, as the ADON and she became the DON on NJ Ex Order 26, when the previous DON left. The LNHA confirmed that the facility had no ADON from NJ Exec Order 26.4b1, when the IP/LPN became the IP until U.S. FOIA (b)(6). The LNHA confirmed the IP was the ADON as a LPN and not a RN as required. The LNHA stated the facility was actively seeking an ADON.	S1690	committee. the QAPI committee meets quarterly.	
S2120	8:39-31.1(c) Mandatory Physical Environment (c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, P.O. Box 809, Trenton, New Jersey 08625-0809.	S2120		9/16/24

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S2120	Continued From page 5 This REQUIREMENT is not met as evidenced by: Complaint NJ #:163699 Based on record review and interview, it was determined that the facility failed to ensure that quarterly Uniform Fire Safety Code inspections were conducted in accordance with N.J.A.C 5:70. This deficient practice had the potential to affect all residents and was evidenced by the following: On 8/21/24 at 9:00 AM, during the Life Safety Code entrance conference, the surveyor requested the Regional Maintenance Director (RMD) provide them with the quarterly Uniform Fire Safety Code inspections for 2023 and 2024. On 8/21/24 at 10:30 AM, the surveyor reviewed the quarterly inspections that were provided for 2024, but only one quarterly inspection was provided for 2023 (3rd quarter). On 8/21/24 at 3:00 PM, the surveyor requested from the RMD the missing quarterly reports (first,	S2120	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: No residents were identified. the most recent Quarterly inspection was conducted on 7/30/2024. the facility has confirmed with the local fire marshal that the facility is scheduled to inspected in the month of October. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The administrator educated the US FOIA (b)(6) on the state	

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S2120	Continued From page 6 second, and fourth quarters). The facility's Licensed Nursing Home Administrator (LNHA) was notified of the concern at the Life Safety Code exit conference on 8/22/24. No additional information was provided.	S2120	requirement for quarterly fire inspection on 9/12/24. the maintenance supervisor will track quarterly fire inspections and reach out to the local fire marshal to ensure timely completions. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The maintenance director will audit timely fire inspections quarterly x 3 with the results presented to the QAPI committee. The QAPI committee meets quarterly.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061217		10/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MADISON, LLC	625 STATE HIGHWAY 34 MATAWAN, NJ 07747

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ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/16/2024	ID Prefix S2120 Reg. # 8:39-31.1(c) LSC	Correction Completed 09/16/2024	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	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 ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ **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
315015 Y1	A. Building B. Wing Y2	10/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MADISON, LLC	625 STATE HIGHWAY 34 MATAWAN, NJ 07747

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 F0557	Correction	ID Prefix F0622	Correction	ID Prefix F0657	Correction
Reg. # 483.10(e)(2)	Completed	Reg. # 483.15(c)(1)(i)(ii)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	09/19/2024	LSC	09/18/2024	LSC	09/09/2024
ID Prefix F0658	Correction	ID Prefix F0755	Correction	ID Prefix F0761	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	09/09/2024	LSC	09/18/2024	LSC	09/09/2024
ID Prefix F0770	Correction	ID Prefix F0825	Correction	ID Prefix F0919	Correction
Reg. # 483.50(a)(1)(i)	Completed	Reg. # 483.65(a)(1)(2)	Completed	Reg. # 483.90(g)(1)(2)	Completed
LSC	09/09/2024	LSC	09/09/2024	LSC	09/20/2024
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?
8/27/2024	☐ 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
315015 Y1	A. Building B. Wing Y2	10/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0657	Correction	ID Prefix F0658	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	09/09/2024	LSC	09/09/2024	LSC	09/18/2024
ID Prefix F0761	Correction	ID Prefix F0825	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.65(a)(1)(2)	Completed	Reg. #	Completed
LSC	09/09/2024	LSC	09/09/2024	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?
8/27/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
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COMPLETE CARE AT MADISON, LLC	625 STATE HIGHWAY 34 MATAWAN, NJ 07747

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/16/2024	ID Prefix S1690 Reg. # 8:39-25.2(d) LSC	Correction Completed 09/20/2024	ID Prefix S2120 Reg. # 8:39-31.1(c) LSC	Correction Completed 09/16/2024
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	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: 1VR812

STATE FORM: REVISIT REPORT (11/06)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. BUILDING **01** B. WING _____	**08/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MADISON, LLC	**625 STATE HIGHWAY 34** **MATAWAN, NJ 07747**

(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/21/24 and 08/22/24, 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 Madison is a 1-story building with a basement that was built on 01/01/1967. It is composed of Type II unprotected construction. The facility is divided into 11 smoke zones. The sprinkler system is on domestic water with no fire pump. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. Emergency backup power to the building is supplied by a an exterior diesel fueled generator. The generator is stated to supply approximately 100% of the building including fire alarm control panel, cross corridor doors (tied to the fire alarm system) hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 167 certified beds.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the	K 222		9/16/24

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

Electronically Signed | 09/13/2024

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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K 222	Continued From page 1 use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.	K 222		

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/21/2024 and 08/22/2024 in the presence of the[US FOIA (b)(6)), it was determined that the facility failed to ensure doors that were installed with delayed-egress systems were properly labeled in accordance with NFPA 101:2012 Edition, Sections 19.2.2.2.4, 19.2.2.5 and 7.2.1.6. This deficient practice was observed for 2 of 11 tested doors, had the potential to affect all residents and was evidenced by the following. An observation on 08/21/2024 at 1:35 PM, revealed that the delayed-egress emergency exit near room A 15 was not provided with a readily visible sign that read "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". An observation on 08/22/24 at 9:38 AM revealed that the delayed-egress emergency exit door #3	K 222	1. Signage was posted on 8/27/24 on exit door near [redacted] and exit door #3 on the sub acute unit with instructions for delayed egress. 2. All residents can be affected. A audit of all delay egress doors was done on 9/2/2024. 3. The maintenance Supervisor will add delayed egress exit signage inspections to the quarterly maintenance checklist. The Maintenance supervisor was inserviced by the Administrator on 9/11/24 about egress door signage. 4 Maintenance director or designee will audit exit signage quarterly, results of the audit will be submitted to the administrator at the monthly QAPI meeting.	

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K 222	Continued From page 3 on the sub acute unit was not provided with a readily visible sign that read "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" In interviews at the time of the observations, the [redacted] confirmed the observations. The facility's [redacted] was notified of the deficient practice during the Life Safety Code exit conference on 8/22/2024. N.J.A.C 8:39-31.2(e)	K 222		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/22/24 in the presence of the [redacted], it was determined that the facility failed to ensure that doors in an	K 223	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE:	9/19/24

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K 223	Continued From page 4 exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position in accordance with NFPA 101 (2012) Sections 19.2.2.2.7 and 7.2.1.8.2 and NFPA 80 Section 5.2.4.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:00 AM revealed that the latching hardware was missing on the fire rated door assembly for the stairwell near the boiler room in the basement preventing the door from completely closing and latching when it was tested by the [redacted] In an interview at the time of observation, the [redacted] confirmed that the fire rated door assembly was missing the latching hardware and did not completely close. The facility's[redacted] was informed of the deficient practice during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e) NFPA 80	K 223	New Latching hardware was installed on 9/13/24 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. An audit of all stairway self-latching doors was completed. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The maintenance supervisor will add stairway self-closing and latching device audit to his quarterly maintenance checklist. The maintenance supervisor was educated by the administrator on 9/12/24 about self closure door requirements. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance director or designee will audit stairways doors for placement self-closing and latching devices monthly x 3 months, results of the audit will be submitted to the administrator at the quarterly QAPI meeting.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101	K 293		9/19/24

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K 293	Continued From page 5 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/22/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that a sign with directional indicator showing the direction of travel was provided in every location where the direction of travel to reach the nearest exit is not apparent in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:05 AM, revealed that at the top of the corridor ramp fork leading to the A-wing unit was no exit directional indicator showing the direction of travel to the nearest exit. In an interview at the time of the observation, the U.S. FOIA (b)(6) [redacted] confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit conference on 08/22/24. N.J.A.C 8:39-31.2(e)	K 293	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: An exit directional sign was installed at the top of the A wing ramp. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The maintenance director will add fire exit directional signage inspections to his quarterly maintenance checklist. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance director or designee will	

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K 293	Continued From page 6	K 293	audit exit directional signage quarterly, results of the audit will be submitted to the administrator at the Quarterly QAPI meeting.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		9/19/24

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K 321	Continued From page 7 Based on observations and interviews on 08/22/2024 in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2, 19.3.5.9 and 8.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:25 AM, revealed that the laundry room door did not latch closed when tested by the U.S. FOIA (b)(6) An observation at 10:30 AM, revealed that the left door leaf of the maintenance repair shop was not provided with a means to self close or automatically close. An observation at 10:48 AM, revealed that the storage room door in the basement did not properly sit in the door frame leaving a 2 inch space between the door edge and the door frame when the door was in the closed position. In interviews at the time of the observations, the [redacted] confirmed the observations. The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit conference on 08/22/24 N.J.A.C 8:39-31.2(e)	K 321	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: A auto closure device was installed on the laundry door and maintenance shop doors. The frame of the storage room door was repaired to allow proper closure. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The US FOIA (b)(6) [redacted] was in serviced by the administrator on 9/12/2024 about the requirement for storage areas to have auto closures on. Storage area auto closures inspections will be added to the monthly preventative maintenance schedule. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: the Maintenance Director or designee will audit 5 storage areas monthly x4 then 5 areas quarterly times 2 to ensure auto closure is in place. With results reported to the quarterly QAPI meeting.	

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K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 08/21/2024 and 08/22/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that semi-annual fire alarm system inspections, testing and maintenance (ITM) and smoke detector sensitivity testing were conducted in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70, and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview on 08/21/2024 at 9:00 AM during the Life Safety Code entrance conference, the surveyor requested fire alarm system ITM from the [redacted]. Documentation review at 10:30 AM, revealed that annual fire alarm inspections for 2022 and 2023 were provided but semi-annual inspections were not provided for 2023 and 2024. No documentation was provided regarding smoke detector sensitivity testing. In an interview at 3:00 PM with the [redacted], the	K 345	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Semi Annual inspection testing has been set up with the fire system vendor. A sensitivity test was conducted on 9/3/2024. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The US FOIA (b)(6) [redacted] was educated by the administrator on 9/12/24 on fire alarm system testing and smoke sensitivity testing. Semi annual fire alarm system testing has been scheduled with the fire system vendor. Smoke sensitivity testing will be scheduled per requirement.	9/19/24

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K 345	Continued From page 9 surveyor requested semi-annual inspections for 2023 and 2024 of the fire alarm system and smoke detector sensitivity testing. In an interview on 08/22/2024 during the Life Safety Code exit conference, a copy of the semi-annual fire alarm inspection was provided for 2024 but no further documentation was provided regarding the semi-annual fire alarm inspections for 2023. No documentation regarding smoke detector sensitivity testing was provided. The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit conference on 08/22/2024. N.J.A.C 8:39-31.2(e) NFPA 70, 72	K 345	HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance director or designee will track fire system testing for semi annual completion and smoke sensitivity testing for bi-annual completion. Quarterly audits will be conducted on with the results submitted to the administrator at the quarterly QAPI meeting.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K 353		9/19/24

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K 353	Continued From page 10 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/22/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that sprinkler system gauges were replaced or recalibrated every 5 years in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:50 AM, revealed that a gauge on the sprinkler system in the laundry room was dated 2018. An observation at 11:00 AM, revealed that gauges on the car garage sprinkler system were dated 2018. In interviews at the time of the observations, the US FOIA (b) [redacted] confirmed the observations. The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit conference on 08/22/24. N.J.A.C 8:39-31.2(e) NFPA 25	K 353	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Sprinkler gauge replacement has been scheduled with sprinkler vendor. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The US FOIA (b)(6) [redacted] was educated by the administrator on 9/12/24 on sprinkler Gauges requiremnts. A tracker for all gauges was created and will be tracked by the maintenance supervisor.. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance director or designee will audit Sprinkler Gauges to ensure they within 5 years as required, monthly x3 with	

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COMPLETE CARE AT MADISON, LLC	625 STATE HIGHWAY 34 MATAWAN, NJ 07747

(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 353	Continued From page 11	K 353	the results reported to the QAPI committee. The QAPI committee meets quarterly.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/21/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that portable fire extinguishers were installed so that the top of the fire extinguisher is not more than 5 feet above the floor in accordance with NFPA 101:2012 Edition, Sections 9.7.5 and NFPA 10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 8/21/2024 at 1:10 PM, revealed that the portable fire extinguisher near the A-Wing parking lot exit door was installed at a height of 63-inches above the floor. An observation at 1:35 PM, revealed that the fire extinguisher at the exit door near room A 15 was installed at a height of 63-inches above the floor. In interviews at the time of the observations, the US FOIA (b) [redacted] confirmed the observations. The facility's US FOIA (b)(6) [redacted] was notified of the	K 355	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The fire extinguisher located at room NJ Exec Ord [redacted] and at the A wing parking lot door were lowered. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. all fire extinguishers were audited. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The US FOIA (b)(6) [redacted] was educated by the administrator on 9/12/24 on fire extinguisher height requirements. HOW THE FACILITY WILL MONITOR	9/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. BUILDING 01 B. WING	08/27/2024

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K 355	Continued From page 12 deficient practice at the Life Safety Code exit conference on 08/22/24. N.J.A.C 8:39-31.2(e) NFPA 10	K 355	ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance director or designee will audit all fire extinguishers for proper placement monthly x 3 with the results presented to the QAPI committee. The QAPI Committee meets quarterly.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 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 interview on 08/21/2024 in the presence of the U.S. FOIA (b)(6) and U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105, and NFPA 80:2010 Edition. This	K 372	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Door sweeps were installed on 9/13/24 for the A unit entrance door, barrier door near room A-30, barrier door near room B-24 and Barrier door near B wing central Bath . The Barrier door at room C-4 was	9/19/24

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	315015	A. BUILDING 01 B. WING	08/27/2024

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K 372	Continued From page 13 deficient practice had the potential to affect all residents and was evidenced by the following: An observation on at 1:10 PM, revealed that the smoke/fire barrier door leading into the A-Wing unit had a 1-inch gap under the door. An observation at 1:15 PM, revealed that the smoke/fire barrier door near room A 30 had a 1-inch gap under the door. An observation at 2:05 PM, revealed that the smoke/fire barrier door near the men's central bath had a 1-inch gap under the door. An observation 2:35 PM, revealed that the smoke/fire barrier door near room B 24 had a 1-inch gap under the door. An observation at 2:40 PM, revealed that the smoke/fire barrier door near room C 4 did not completely close when tested by the US FOIA (b)(6) In interviews at the time of the observations, the US FOIA (b)(6) confirmed the findings. The facility's US FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 08/22/2024. N.J.A.C 8:39-31.2(e) NFPA 80, 105	K 372	adjusted to allow for full closure on 9/13/24. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The US FOIA (b)(6) was educated by the administrator on 9/12/24 on Smoke barrier door requirements. All Barrier doors will be audited yearly to ensure smoke barriers are in compliance. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance director or designee will all audit smoke barrier doors for compliance monthly x 2 months then quarterly x 2 quarters. The results will be presented to the QAPI committee. The QAPI committee meets quarterly.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in	K 521		9/19/24

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	315015	A. BUILDING 01 B. WING	08/27/2024

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K 521	Continued From page 14 accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 08/21/2024 and 08/22/2024 in the presence of the NJ Exec Order 26.4b1 [redacted], it was determined that the facility failed to ensure that resident bathrooms were provided with ventilation in accordance with NFPA 101:2012 Edition, Sections 19.5.2, 9.2.1 and NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 08/21/2024 at 1:22 PM, revealed that the ventilation in room A 26 bathroom was not functioning when tested by the US FOIA (b)[redacted]. An observation at 2:22 PM, revealed that the ventilation in room B 13 bathroom was not functioning when tested by the US FOIA (b)(6) An observation at 2:30 PM, revealed that the ventilation in room B 18 bathroom was not functioning when tested by the US FOIA (b)(6). An observation at 2:40 PM, revealed that the ventilation in room C 35 bathroom was not functioning when tested by the US FOIA (b)(6). An observation at 2:45 PM revealed that the	K 521	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Rooftop ventilation fans were repaired. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. All rooftop fans were audited by the Regional Maintenance Assistant on 9/2/24 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The US FOIA (b)(6) [redacted] was educated by the administrator on 9/12/24 on ventilation for bathroom requirements. Bathroom ventilation audits will be added to the monthly maintenance audit schedule HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. BUILDING **01** B. WING _____	**08/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 521	Continued From page 15 ventilation in room C 13 bathroom was not functioning when tested by the US FOIA (b)(6) The facility's U.S. FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 08/22/2024. N.J.A.C 8:30-31.2(e) NFPA 90A	K 521	PROGRAM WILL BE PUT INTO PLACE: The Maintenance director or designee will audit 1 bathroom on each nursing unit for functionality of the bathroom vent monthly x 3 months then quarterly x 2 quarters with the results submitted to the QAPI committee. The QAPI committee meets quarterly.	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	K 741		9/19/24

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K 741	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/21/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that metal containers with self-closing cover devices and ashtrays of non-combustible material were provided and readily available to all areas where smoking was permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:00 PM, revealed that the resident smoking area contained 2 plastic smokeless ashtrays and was not provided with a metal container into which ashtrays could be emptied. In an interview at the time of the observation, the U.S. FOIA (b) confirmed the findings. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit conference on 08/22/2024. N.J.A.C 8:39-31.2(e)	K 741	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: New non combustible ashtrays were ordered and installed. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The US FOIA (b)(6) [redacted] were educated by the administrator on 9/12/24 on smoke ashtray requirements. The facility policy was updated to only purchase and use non combustible material ashtrays. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance director or designee will audit monthly x 3 to ensure proper non combustible smoke ashtrays are in place. Audit results will be presented to the QAPI committee, the QAPI committee meets quarterly.	

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K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 08/21/2024 and 08/22/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that Inspections, Testing and Maintenance (ITM) of fire/smoke door assemblies were conducted annually in accordance with NFPA 101:2012 Edition, Sections 7.2.1.15, 19.7.6, 8.3.3.1, NFPA 105: 2010 Edition, Sections 4.1.1, 5.2.1 and NFPA 80: 2010 Edition, Sections 5.2.1, 5.2.4.2 . This deficient practice had the potential to affect all residents and is evidenced by the following: In an interview on 08/21/2025 at 9:00 AM during the Life Safety Code entrance conference, a request was made for fire/smoke door ITM to the US FOIA (b) [redacted]. Documentation review at 10:00 AM, revealed that	K 761	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: An audit on all fire door assemblies was completed by the regional maintenance director on 9/12/2024. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The US FOIA (b)(6) [redacted] was educated by the administrator on annual	9/19/24

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K 761	Continued From page 18 there was no documentation regarding fire or smoke door assembly inspections. In an interview at 3:00 PM, a request was made to have fire/smoke door assembly ITM available for review the following morning. No documentation was provided regarding fire/smoke door assembly ITM. The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit conference on 08/22/2024. N.J.A.C 8:39-31.2(e) NFPA 80, 105	K 761	maintenance, inspecting and testing of fire door assembly on 9/12/24. Fire door assembly audits will be added to the yearly maintenance audit cycle. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance director or designee will audit monthly x3 to ensure proper fire/smoke door inspections are documented. Audit results will be presented to the QAPI committee. The QAPI committee meets quarterly.	

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
315015 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MADISON, LLC	625 STATE HIGHWAY 34 MATAWAN, NJ 07747

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 K0222	09/16/2024	LSC K0223	09/19/2024	LSC K0293	09/19/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	09/19/2024	LSC K0345	09/19/2024	LSC K0353	09/19/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	09/19/2024	LSC K0372	09/19/2024	LSC K0521	09/19/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0741	09/19/2024	LSC K0761	09/19/2024	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? ☐ YES ☐ NO
8/27/2024	