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 09/13/2021

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
F 000	INITIAL COMMENTS Complaint #: NJ147421, NJ147042 Census: 92 Sample Size: 5 The facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this Complaint Survey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		10/31/21

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

Electronically Signed | 09/29/2021

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 09/13/2021

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
F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint Intake: NJ147421 Based on interviews, record review, and facility policy review, it was determined that the facility failed to inform a responsible party of a resident's [redacted]. This affected 1 (Resident [redacted]) of 3 residents reviewed for timely notification of a change of condition. Findings included: 1. Record review of a face sheet revealed Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted] The	F 580	The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. This plan of correction constitutes a written allegation of substantial compliance with Federal and State Medicare and Medicaid. 1. One resident affected by deficient practice 2. All residents have the potential to be affected by deficient practice. 3. Nursing Staff in-service was initiated on September 23, 2021 by Nurse Practice Educator on the importance of notifying family/responsible party as necessary.	

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 09/13/2021

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
F 580	Continued From page 2 quarterly Minimum Data Set, dated [redacted], revealed a Brief Interview for Mental Status (BIMS) of [redacted] out of [redacted] indicating [redacted] Resident [redacted] was dependent on the care of at least one person for all activities of daily living (ADLs) and needed assistance to eat. Resident [redacted] had a care plan, dated [redacted], addressing being at risk for [redacted] with an intervention to have the resident up in a [redacted] chair ([redacted], a [redacted] and to sit in the day room in front of the nurses' station for monitoring. The resident was on [redacted] During an interview on 09/11/2021 at 1:15 PM, the Director of Nursing stated that on [redacted], Resident [redacted] experienced a fall by tipping the [redacted] chair backwards. Registered Nurse (RN) #1 witnessed the incident but failed to inform the responsible party. The facility informed the responsible party on [redacted], six days after the [redacted]. On 09/10/2021 at 2:40 PM, RN #1 was interviewed. RN #1 stated she had been working at the facility since [redacted] through agency nursing. She revealed having received several trainings from the facility about the importance of reporting any change of condition with a resident whether it included an injury or not. RN #1 did not mention why she did not report the [redacted] (on [redacted]) to the responsible party, except to say, "I forgot." On 09/11/2021 at 1:15 PM, the DON was interviewed about RN #1. The DON indicated RN #1 was from an agency and she had been provided with education and expectations	F 580	4. The Director of Nursing or designee will maintain logs weekly x 4, monthly x 3 to ensure compliance. Any issues of non-compliance will be reported to the Administrator for resolution. Results will be provided to the QAPI Committee monthly and ongoing for review/recommendations. Date of completion: 10/31/2021	

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 09/13/2021

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
F 580	Continued From page 3 regarding the protocol of the facility. The DON revealed her expectation was when a resident had a [redacted], injury or not, it was the nurse's responsibility to inform the responsible party of the incident. The DON indicated she was not aware Resident [redacted] had tipped the [redacted] chair backwards until [redacted]. She indicated calling the responsible party on [redacted] to inform the responsible party about the [redacted]. On 09/11/2021 at 1:33 PM, the Regional Clinical Supervisor (RCS) was interviewed about RN #1 and the incident. The RCS indicated when she interviewed RN #1, RN #1 did not feel as though the incident was a [redacted] since Resident [redacted] had tipped the [redacted] chair backwards, leaving the resident's [redacted] in the air. Therefore, RN #1 did not document the incident or inform the responsible party. The facility policy, titled, Change in Resident's Condition or Status, dated May 2020, Policy Statement read, in part, Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status.	F 580		
F 609 SS=D	New Jersey Administrative Code § 8:39-5.1(a) Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		10/31/21

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 09/13/2021

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
F 609	Continued From page 4 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake: NJ147042 Based on record reviews, interviews, and facility policy review, it was determined that the facility failed to ensure an injury of unknown origin was reported to the State Survey Agency. This affected 1 (Resident [redacted]) of 3 residents being reviewed for a [redacted]. Findings included: 1. Record review of a face sheet revealed Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted]. The quarterly	F 609	1. Resident [redacted] was discharged on [redacted] 2. All residents have the potential to be affected by deficient practice. 3. Nursing Staff and Managers in-service was initiated on September 23, 2021 by Nurse Practice Educator on the importance of notifying regulatory agencies, including but not limited to the New Jersey Department of Health. 4. All incidences/allegations/grievances will be reviewed by Administrator weekly x4, monthly x3 to ensure that all incidences/allegations/grievances have been reported to appropriate regulator entities	

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 09/13/2021

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
F 609	Continued From page 5 Minimum Data Set, dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted], indicating [redacted] status. Resident [redacted] was completely dependent with activities of daily living (ADLs). Resident [redacted] was [redacted] and received [redacted] through a [redacted]. During an interview on 09/11/2021 at 10:18 AM, the Director of Nursing (DON) stated that on the morning of [redacted] at approximately 6:00 AM, Resident [redacted] was being prepared for [redacted] when it was discovered the resident was experiencing a [redacted]. The physician was informed and prescribed clonidine to raise the [redacted], and the resident was transported to [redacted]. The [redacted] center was in the same facility as the nursing home. The [redacted] center was unable to provide [redacted] to Resident [redacted] due to the continued [redacted] and called 911 to have the resident sent to the hospital. The hospital reported back to the facility that on the evening of [redacted], Resident [redacted] was admitted with [redacted] and a [redacted]. On 09/10/2021 at 4:10 PM, the [redacted] registered nurse ([redacted] RN) was interviewed about the incident with Resident [redacted]. The [redacted] RN indicated she called 911 when Resident [redacted]s [redacted] remained too low to perform the [redacted] session. Per the [redacted] RN, Resident [redacted] never indicated being in [redacted], nor did the resident ever mention being dropped. On 09/11/2021 at 9:44 AM, Registered Nurse (RN) #2 was interviewed about Resident [redacted]. RN #2 revealed she was the one who took the call from the hospital to inform the facility Resident [redacted] was being admitting for the [redacted].	F 609	5. The Director of Nursing or designee will maintain logs weekly x 4, monthly x 3 to ensure compliance. Any issues of non-compliance will be reported to the Administrator for resolution. Results will be provided to the QAPI Committee monthly and ongoing for review/recommendations. Date of completion: 10/31/2021	

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 09/13/2021

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
F 609	Continued From page 6	F 609		

RN #2 indicated the hospital was not going to share any information about how the [redacted] was sustained. RN #2 informed the RN house supervisor, RN #3, about the [redacted] RN #2 indicated Resident [redacted] had a bed bath the morning of [redacted], and if the resident had a [redacted], it would have been observed at that time.

The Director of Nursing (DON) was interviewed on 09/11/2021 at 10:18 AM regarding the incident. The DON revealed an investigation began as soon as the facility was informed of Resident [redacted] having a [redacted]. Per the DON, the investigation indicated Resident [redacted] had not suffered a [redacted] prior to going to the [redacted] appointment. The DON indicated the facility did not report the incident because they were unable to prove Resident [redacted] obtained the [redacted] at the facility. The DON stated, "If there was anything I could have proved happened here, then I absolutely would have reported it to the state."

The Regional Clinical Supervisor's (RCS) interview on 09/11/2021 at 10:28 AM revealed that as part of the facility's investigation, the staff re-enacted the events of the day, and the resident was fine when the resident left for [redacted]. She indicated that if the facility's investigation revealed the [redacted] happened at the facility, then the state would have been notified. The RCS indicated when the facility was informed about the [redacted], Resident [redacted] was no longer in their care. They decided to not report the incident to the state agency, because they did not believe the [redacted] occurred at the facility.

The facility policy, titled, Unusual Occurrence

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 09/13/2021

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
F 609	Continued From page 7 Reporting, dated January 2021, read in part, #2. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within 24 hours of such incident or as otherwise required by federal and state regulations. #3. A written report detailing the incident and actions taken by the facility after the event shall be sent of delivered to the state agency within 48 hours of reporting the event or as required by federal and state regulations. New Jersey Administrative Code § 8:39-5.1(a)	F 609		