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 _____	12/09/2022

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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 12/09/2022 Census: 114 Sample: 24 plus 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to	F 637	1 Resident # 36 MDS Assessment was	1/6/23

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

Electronically Signed | 01/02/2023

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F 637	Continued From page 1 ensure that a significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care was completed. This deficient practice was identified for 1 of 27 residents reviewed, (Resident #36) for accurate completion of a significant change MDS. The deficient practice was evidenced by the following: On 11/28/22 at 10:45 AM, the surveyor observed Resident #36 lying in bed. At that time, the surveyor attempted to interview the resident. The resident was NJ Exec. Order 26:4.b.1 , made eye contact with the surveyor, shook his/her head and smiled. The surveyor further observed that the resident's EX Order 26.4B1 were EX Order 26.4B1 . On 11/30/22 at 10:56 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that Resident #36 was EX Order 26.4B1 from EX Order 26.4B1 on EX Order 26.4B1 . On 12/01/22 at 11:19 AM, the surveyor interviewed the Minimum Data Set/Registered Nurse (MDS/RN) in the presence of the Regional/Minimum Data Set/Registered Nurse (R/MDS/RN). The MDS/RN stated, "The MDS EX Order 26.4B1 area documented as the patient being on EX Order 26.4B1 was an error." The surveyor reviewed the medical record for Resident #36. A review of the Admission Record, reflected that Resident #36, was admitted to the facility on EX Order 26.4B1 with a diagnosis which included but not limited to unspecified EX Order 26.4B1 EX Order 26.4B1 .	F 637	Modified on 12/1/2022 to Reflect the Significant Change of Status Assessment that she is no Longer in EX Order 26.4B1 as of EX Order 26.4B1 . 2 All Residents that have a Significant Change in Condition Have the Potential to be Affected by the Same Deficient Practice. 3 In-services were provided on 12/7/22 to all Members of IDC team to Communicate any Potential Change in Residents Condition that may Require a Significant Change of Status Assessment to the entire IDC team via written communication to Ensure that the Assessments are Completed in a Timely Manner. Hospice residents will be reviewed weekly by the IDC team to communicate any changes in condition The MDS coordinator is responsible for ensuring timely completion of MDS significant change assessments. 4 DON or designee will Audit 2 charts weekly x 4 weeks, monthly x 2 months, then quarterly x1 quarter to ensure any significant changes have corresponding significant change MDS assessments completed timely. Results of the Audit will be reported to the Administrator and will be Presented in the QAPI to Ensure that the System in Place are Effective.	

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F 637	Continued From page 2 A review of the residents annual MDS dated 08/9/22, reflected the Brief Interview for Mental Status score (BIMS) of [redacted] out of 15 which refelcted the resident had EX Order 26.4B1. A further review of the resident's MDS, Section - O - Special Treatments, Procedures, and Programs indicated that the resident was on EX Order 26.4B1 services. A review of the residents Significant Change MDS dated EX Order 26.4B1 revealed in Section - O - Special Treatments, Procedures, and Programs that the resident was receiving Ex Order 26.4B1. A review of the Ex Order 26.4B1 Visit Note dated EX Order 26.4B1, provided by the Director of Nursing (DON) on 12/1/22 at 8:30 AM, revealed that Resident #36 was admitted to EX Order 26.4B1 on EX Order 26.4B1 and EX Order 26.4B1 from EX Order 26.4B1 services on EX Order 26.4B1 A review of the CMS's RAI version 3.0 Manual for MDS revealed a provider should Code residents identified as being in a EX Order 26.4B1 program. NJAC 8:39-11.2	F 637		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 658	1	1/6/23

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F 658	Continued From page 3 review, it was determined that the facility failed to follow acceptable professional standards of clinical practice by not accurately administering a medication, Ex Order 26.4B1 using the proper technique. The deficient practice was identified for one of two nurses observed during medication administration for one of four residents, (Resident #61). The deficient practice was evidenced by the following: 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 registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 658	Resident # 61 Ex Order 26.4B1 record was reviewed. Ex Order 26.4B1 reading was Ex Order 2 mg/dl Ex Order 26.4B1 . and Ex Order 26.4B1 Ex Order 26.4B1 or dipped below 60 for the next 14 days. The Registered Nurse who did not Prime the Ex Order 26.4B1 and did not Hold the Button for 10 seconds was In-service individually on how to administer Ex Order 26.4B using a Ex Order 26.4B1 device and Competency Evaluation was also done on Ex Order 26.4B1 2 All Residents that Receive Ex Order 26.4B1 Via a Ex Order 26.4B1 Device have the Potential to be Affected with the same Deficient Practice. 3 All Nurses were In-service on the Difference between Administering Ex Order 26.4B via a Regular Ex Order 26.4B Needle VS Administering Ex Order 26.4B using a Ex Order 26.4B1 Ex Order 26.4B1 Device. Competency Audit on Administering Ex Order 26.4B Via a Ex Order 26.4B1 Device will be done to all nurses (RN'S LPN'S) by DON or designee Competency Audit will be completed by 01/06/2023. Ex Order 26.4B1 Administration Via Ex Order 26.4B1 Ex Order 2 Device will be incorporated in the Orientation Process to ensure that all new hire knows the procedure and the difference between Ex Order 26.4B1 given through a regular Ex Order 26.4B1 needle VS Ex Order 26.4B1 Ex Order 2 Device.	

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F 658	Continued From page 4 On 11/30/22 at 8:51 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN) preparing to administer medications to Resident #61. The RN stated that she had to administer a long-acting [redacted] to the resident. The surveyor observed the RN remove an [redacted]) (a long-acting synthetic version of [redacted] used to replace the [redacted] normally produced and [redacted] labeled for Resident #61 from the medication cart. The RN stated that the [redacted] was [redacted] and dialed the [redacted] device to [redacted] and showed the surveyor the number [redacted] in the dose window section of the [redacted] There was no initial priming prior to dialing the dose to be administered. On 11/30/22 at 9:02 AM, the surveyor observed the RN administer the [redacted] device [redacted] into Resident #61 by injecting the needle of the [redacted] pushing the injector button down, and holding the [redacted] for approximately less than two (2) seconds. The surveyor reviewed the medical record for Resident #61. A review of the resident's Admission Record revealed diagnoses which included [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the	F 658	4. DON or designee will observe 3 nurses administer [redacted] injections weekly x4 weeks, then monthly x 2 months. Results of the Audits will be reported to the administrator and presented at the monthly QAPI meetings	

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F 658	Continued From page 5 management of care, dated EX Order 26.4B1 reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating that the resident had an intact EX Order 26.4B1. A review of the Ex Order 26.4B1 Order Summary Report reflected a physician's order (PO) dated EX Order 26.4B1 for EX Order 26.4B1), EX Order 2 EX Order 26.4B1 in the morning for Ex Order 26.4 A review of the Ex Order 26.4B1 electronic medication administration record (EMAR) reflected the same PO dated Ex Order 26.4B1 with an administration time of 8:00 AM. On 11/30/22 at 10:05 AM, the surveyor interviewed the RN who stated that the Ex Order 26.4B Ex Order 26.4B1 was administered Ex Order the same as using a Ex Order 26.4B1 except the Ex Order 26 had a dialing calibration for the dose. On 11/30/22 at 10:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN)/Unit Manager (UM) who stated that Ex Order 26.4B was injected Ex Order 2 the same method whether a Ex Order 26.4B1 was used. On 11/3022 at 10:15 AM, the surveyor interviewed the LPN/Infection Preventionist (IP) who stated that she started in the role of IP in the last three months but previous to that was the LPN/UM on the Ex O wing. The LPN/IP added that she was considered a staff educator. The LPN/UM was unable to speak to the technique for administration of an Ex Order 26.4B1 device and further stated that she would have to get the information. On 11/30/22 at 11:25 AM, the surveyor	F 658		

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F 658	Continued From page 6	F 658		

interviewed the Director of Nursing (DON) and LPN/IP. The LPN/IP stated that there was a difference in the method of administration of Ex Order 26.4B when using a Ex Order 26.4B1 versus a Ex Order device. The DON stated that the Ex Order 26.4B1 device required two U to be discarded before dialing the actual dose for administration. The DON added that when the Ex Order 26.4B1 device was injected, the plunger needed to be held in for six to 10 seconds before removing. The DON then stated that the nurses were instructed on the Ex Order 26.4B1 device administration technique when the Ex Order 26.4B1 first came out and was unsure if there had been an in-service recently.

On 11/30/22 at 2:36 AM, the DON provided the surveyor with surveyor an in-service dated NJ Exec. Order 26, for "Administering Medications"," Ex Order 26.4B1 Ex Order 26 Instructions" and "Charting and Documentation." The RN NJ Exec. Order 26: attended the in-service.

In addition, the DON provided the surveyor with a Medication Pass Observation Worksheet dated NJ Exec. Order 26:4.b.1 was completed by the Consultant Pharmacist (CP) for the RN. The worksheet indicated that the RN had "Proper technique with Ex Order 26.4B1."

On 12/2/22 at 9:13 AM, the surveyor, in the presence of the survey team, interviewed the CP. The CP stated that he had not seen Ex Order 26.4B1 used that much in the facility. The CP stated that the proper technique that he would expect to see when using the Ex Order 26.4B1 device was that the pen was primed before administering the actual dose and when injected the plunger had to be held in place to ensure the entire dose was administered.

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F 658	Continued From page 7 On 12/2/22 at 10:16 AM, the surveyor interviewed Resident #61 who stated that the nurses administered his/her Ex Order 26.4BT injections and had no issues. The resident was NJ Exec. Order 26:4.b.1 to the method of administration of the Ex Order 26.4BT device. A review of the facility policy, "Insulin Administration" updated 10/2019, provided by the DON reflected that, "The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to use." A review of the manufacturer specifications for instructions on how to administer Insulin Glargine-yfgn (Semglee) using the prefilled pens reflected, "Always do a safety test before each injection." The specifications add that a safety test checks that the pen and the needle are working properly and will make sure the patient will receive the correct dose. Further instructions indicate that to do a safety test, "Select 2 units by turning the dose selector until the dose pointer is at the 2 mark. Press the inject button all the way in. When insulin comes out of the needle tip, your pen is working correctly." Further review of the manufacturer specifications for instructions indicated when injecting the insulin pen to "Keep the injection button held in and when you see "0" in the dose window, slowly count to 10. This will make sure you get the full dose." NJAC 8:39- 11.2(b), 27.1(a), 29.2(d)	F 658		
F 684 SS=E	Quality of Care	F 684		1/6/23

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F 684	Continued From page 8 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) routinely change the dressing surrounding a EX Order 26.4B1 [redacted]), b.) obtain a Physician's Order (PO) to flush the [redacted] Ex Order 26.4B1 [redacted] and c.) develop a comprehensive care plan for the care of the [redacted]. This deficient practice was identified for one of one resident's reviewed, (Resident #14) for care related to a [redacted] This deficient practice was evidenced by the following: On 11/28/22 at 12:39 PM, the surveyor observed Resident #14 sitting upright in bed, [redacted] with a sheet covering the resident's body. At that time, the surveyor observed that the resident had a [redacted] in his/her right [redacted]. The surveyor further observed a clear plastic dressing surrounding the [redacted] The edges of the clear,	F 684	1 Resident # 14 Plan of Care was reviewed. Physician Order for Dressing change Weekly and as needed was obtained on 12/2/2022. Physician order for Flushing the Central line every shift was obtained on 12/2/2022. A Care Plan specific for the purpose and maintenance of the Central line was put in place on 12/02/2022. Audit performed on 12/2/22 by the IP found no other residents affected by this alleged deficient practice. 2. All Residents that have a Central Venous Catheter in place have the Potential to be Affected with the same Deficient Practice. 3. All nurses were in serviced that all Central Venus Catheters need orders for weekly and PRN dressings, orders for flushing every shift for patency and care plan for a [redacted]	

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F 684	Continued From page 9 plastic dressing surrounding the [redacted] were observed to be EX Order 26.4B1 up at the sides. The clear plastic dressing was further observed to be undated. The surveyor observed that the resident's EX Order 26.4B1 (a small, flexible, open tubing attached to the [redacted] that medication can be administered into) with two blue caps on them. The resident stated that he/she was re-admitted from the hospital about NJ Exec. Order 26:4.b.1 ago and the staff working at the facility had only changed the dressing to the [redacted] once since his/her re-admission to the facility. The resident told the surveyor that facility staff had not been flushing his/her [redacted] with [redacted] (EX Order 26.4B1 [redacted] On 11/30/22 at 11:36 AM, the surveyor observed the resident lying in bed naked with a sheet covering the resident's EX Order 26.4B1. The resident stated that the staff changed the dressing to the [redacted] yesterday ([redacted]). The surveyor observed that the clear, plastic dressing surrounding the [redacted] was curling up at the edges and undated. On 12/02/22 at 10:06 AM, the surveyor observed the resident sitting upright in bed scrolling through Face Book (FB) on his/her cell phone. The surveyor observed a clear, plastic dressing over the [redacted] on the resident's EX Order 26.4B1. The dressing was dated [redacted] The surveyor reviewed the electronic medical record for Resident #14. A review of the resident's Admission Record reflected that the resident was admitted to the	F 684	All new admissions will be reviewed by Unit managers for presence of a [redacted], orders for dressing change and line flushing and targeted plans of care. 4. DON or designee will Audit 1 new admission and 1 current chart weekly x4 weeks to ensure that residents with Central Venous Catheter have a Dressing Change Order, Flushing Protocol Order and A Comprehensive Care Plan. This audit will then be completed monthly x2 months. Results of the Audit will be submitted Administrator and will be presented at the monthly QAPI meeting	

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F 684	Continued From page 10	F 684		

facility in the beginning of EX Order 26.4B1 and re-admitted the second week of EX Order 26.4B1 A further review of Resident #14's Admission Record indicated that the resident had diagnoses which included but were not limited to EX Order 26.4B1 [redacted] EX Order 26.4B1).

A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated EX Order 26.4B1, reflected that the resident had a Brief interview for Mental Status (BIMS) score of EX Ord out of 15 which indicated the resident was EX Order 26.4B1

A review of the resident's EX Order 26.4B1 Medication Administration Record (MAR) reflected a prn (as needed) PO dated EX Order 26.4B1, to change Ex Order 26.4B1 site transparent dressing. A further review of the resident's EX Order 26.4B1 MAR did not reveal that the nurses had signed that they changed the resident's EX Order 26 dressing site as needed. The EX Order 26.4B1 MAR further reflected a PO dated EX Order 26.4B1, to change NJ Exec. Order 26:4.b.1 per sterile technique every Monday during night shift. There were no signatures for the above PO on the EX Order 26.4B1 MAR.

The EX Order 26.4B1 MAR indicated a PO dated

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[redacted], to flush each unused [redacted] with [redacted] of [redacted] followed by 10 ml of [redacted]. A review of the [redacted] MAR indicated that the nurses signed that they flushed the [redacted] at 0900 (9:00 AM) and 2100 (9:00 PM) on [redacted]. A further review of the August 2022 revealed no further signatures for the above PO.

A review of the [redacted] Treatment Administration Record (TAR) did not reveal a PO for the dressing change of the [redacted] or a PO to flush the [redacted] to maintain [redacted].

A review of the resident's [redacted] MAR reflected a prn PO dated [redacted], to change [redacted] site transparent dressing. A further review of the resident's [redacted] did not reveal that the nurses had signed that they changed the resident's [redacted] dressing site as needed. A continued review of the [redacted] 2022 MAR revealed a PO dated [redacted], to change [redacted] per sterile technique every week and prn when it became wet or dislodged. The PO reflected to hold the [redacted] dressing change from [redacted]. A further review of the [redacted] reflected that the nursing performed the dressing change to the [redacted] site on [redacted].

The [redacted] MAR indicated a PO dated [redacted], to flush each unused [redacted] with [redacted] of [redacted] followed by [redacted] ml of [redacted] every [redacted] hours for [redacted]. A review of the [redacted] MAR indicated that the nurses signed that they flushed [redacted] at 0900 (9:00 AM) and 2100 (9:00 PM) on [redacted]. A further review of the [redacted] revealed no further signatures for the above PO.

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F 684	Continued From page 12	F 684		

A review of the [redacted] TAR did not reveal a PO for the dressing change of the [redacted] or a PO to flush the [redacted] to maintain [redacted].

A review of the [redacted] MAR did not reveal a PO to change the [redacted] dressing.

A review of the [redacted] MAR revealed a PO dated [redacted], to flush each unused [redacted] with [redacted] followed by [redacted] of [redacted] every [redacted] for [redacted]. A further review of the [redacted] MAR reflected that the nurses signed that they flushed the [redacted] at 0900 (9:00 AM) and 2100 (9:00 PM) from [redacted] through [redacted] The PO was put on hold on [redacted] and [redacted] then discontinued.

A review of the [redacted] TAR did not reveal a PO for the dressing change of the [redacted] or a PO to flush the [redacted] to maintain [redacted].

A review of the [redacted] MAR did not reveal a PO to change the [redacted] dressing. A further review of the [redacted] MAR did not reflect a PO to flush the unused [redacted] of the [redacted] to maintain [redacted]

A review of the [redacted] TAR did not reveal a PO for the dressing change of the [redacted] or a PO to flush the [redacted] to maintain [redacted].

A review of the [redacted] 22 MAR revealed a PO dated [redacted], after surveyor inquiry to flush [redacted] with [redacted], followed by [redacted] every shift. A further review of the December [redacted] reflected a PO dated [redacted] after surveyor inquiry to change [redacted] with transparent dressing on admission, weekly,

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F 684	Continued From page 13 and as needed every Thursday night. A review of the Ex Order 26.4B1 TAR did not reveal a PO for the dressing change of the Ex Order 26 or a PO to flush the Ex Order 26 to maintain Ex Order 26.4B1. A review of the resident's comprehensive care plan did not reveal a focus area that the resident had a Ex Order 26 or goals and interventions for the care of the Ex Order 26 On 12/02/22 at 11:27 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who told the surveyor that she was not the resident's regular assigned CNA, but she had taken care of the resident before and was assigned to care for the resident that day. The CNA stated that the resident was NJ Exec. Order 26:4.b and had a NJ Exec. Order 26:4.b.1. The CNA further stated that she never performed care on the resident's Ex Order 26 because that was the nurses responsibility. On 12/02/22 at 11:37 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that she regularly cared for Resident #14, the resident was NJ Exec. Order 26:4.b and was able to make his/her needs known. The LPN told the surveyor that the resident had a Ex Order 26.4 in his/her Ex Order 26.4B1 and the dressing change for the Ex Order 26.4 was not performed during her shift, but the resident was able to verbalize when he/she wanted the dressing to be changed. The LPN stated that the purpose of routinely changing the dressing to the Ex Order 26 was to prevent an Ex Order 26.4B1. The LPN further stated that the nursing staff flushed the Ex Order 26.4 Ex Order 26.4B1) with Ex Order 26.4B1 and the purpose of Ex Order 26.4B1 was to maintain Ex Order 26.4B1 The	F 684		

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F 684	Continued From page 14 surveyor asked the nurse how frequently the [redacted] to the [redacted] were flushed and the nurse stated that she was unsure, "but it does get flushed." The LPN told the surveyor that if the dressing changed to the central line was being performed and the [redacted] was being flushed, there should have been a PO to reflect the care. The LPN further stated that the purpose of the PO would be to inform the nurses of the frequency and accountability of the care. The LPN stated that if a resident had a [redacted] that would be something that would be care planned for and the unit managers were responsible for creating the care plans for the residents. On 12/02/22 at 11:57 AM, the surveyor reviewed the [redacted] MAR and [redacted] TAR in the presence of the resident's LPN and identified that there were no PO's to sign for changing the resident's [redacted] or flushing the [redacted] On 12/02/22 at 11:59 AM, the surveyor interviewed the resident's Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that she was [redacted]. The LPN/UM further stated that if a resident had a [redacted] there should be a PO to reflect the care of the [redacted] The LPN/UM told the surveyor that the [redacted] should have a PO to be changed weekly and as needed and the lines into the [redacted] should be flushed every shift. The LPN/UM further stated that the dressing change was important because the dressing acted as barrier to prevent infection and flushing [redacted] maintained patency of the [redacted] The LPN/UM stated that the resident's [redacted] should be care planned for.	F 684		

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F 684	Continued From page 15 On 12/02/22 at 12:04 PM, the surveyor interviewed the Director of Nursing (DON) who stated if a resident had a [redacted] the resident should have a PO for the [redacted] dressing to be changed weekly or as needed. The DON further stated that if the resident was not regularly receiving an Ex Order 26.4B1 medication through the [redacted], the [redacted] should be flushed once a shift and the care of the [redacted] should be care planned for. A review of the facility's, "Central Venous Catheter Dressing Changes Policy and Procedure" reviewed 1/10/22, indicated that the purpose of changing a CVC was to prevent infections. The Facility's, "Central venous Catheter Policy and Procedure" further indicated that the documentation that was required to be in the resident's medical record included: the date and time the dressing was changed, the location and objective description of the insertion site, complications and interventions that were performed for the resident, and the signature and title of the person recording the information. The facility's Policy and Procedure did not specify how frequently the resident's CVC was to be changed. A review of the facility's, "Central Venous and Midline Flushing policy and Procedure" reviewed 1/10/22, indicated that the purpose of the procedure was to maintain the patency of the CVC. The facility's "Central Venous and Midline Flushing policy and Procedure" further indicated that when the CVC was flushed, "The following information should be documented in the resident's medical record: 1. The date and time the medication was administered. 2. The amount of flush administered. 3. The route and rate of the medication administered. 4. The condition of the	F 684		

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F 684	Continued From page 16 IV site before and after administration. 5. Notification of the physician, if there are any complications. 6. Resident response. 7. The signature and title of the person recording the data.	F 684		
F 755 SS=D	NJAC 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide 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	F 755		1/6/23

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F 755	Continued From page 17 §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 record review, it was determined that the facility failed to maintain an accurate accountability and reconciliation for two controlled drugs, ([redacted]) for one resident, (Resident #162). The deficient practice was identified for one of three units reviewed for medication storage. The deficient practice was evidenced by the following: 1. On 11/29/22 at 9:46 AM, the surveyor, with the Licensed Practical Nurse (LPN), observed the controlled drugs that were locked in the refrigerator of the [redacted] unit medication storage room for inventory accountability and reconciliation. [redacted] four intravenous (NJ Exec. Order 26:4.b.1 [redacted]) each were labeled for Resident #162. Three of the four bags had the same prescription number on the label and one of the four bags had a different prescription number on the label. At that time, the LPN obtained the corresponding [redacted] ecords (IPCSAR) (a declining inventory record) from a binder on the medication cart for the[redacted]. The LPN showed the surveyor [redacted] different [redacted] for the [redacted] were labeled for Resident #162 with the following documentation:	F 755	1. Resident # 162 [redacted] Supplies was Fully accounted for. The Packing Slip was reviewed with the surveyor and the number of bags that correspond with the packing slip. A Manual PRN Medication Administration Record was created to reflect the actual time when the medication was hanged and when it was taken off along with the corresponding bag with the prescription number. The Pharmacy Provider was notified, and their staff were in-service to send an [redacted]. The Nursing Supervisor was also informed to Notify the Pharmacy if the [redacted] is not received so they can send the form that reflects the prescription number of the medication that was delivered for accountability. All Nurses were also in-service on how to complete the declining sheet for the [redacted]. The destruction date must be within 72 hours different from the application time. 2. All Residents That are Receiving [redacted] and [redacted] Continuous via Pump have the potential to be affected by the same deficient practice. 3.	

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F 755	Continued From page 18 -The first Ex Order 26.4B1 reflected a label from the pharmacy provider that had the quantity filled was Ex Order 26.4B1 containing Ex Order 26.4B1 each with a signature that the Registered Nurse (RN) signed as a received date of Ex Order 26.4B1. The "amount received" was blank and in the lower left-hand corner was handwritten "[redacted]." The prescription number on the label corresponded with the one of four bags that was stored in the [redacted] unit refrigerator. There was no documentation that any of the bags were removed from inventory and that the inventory should be a total of four bags. The Ex Order 26.4B1 reflected a handwritten label for Resident #162 Ex Order 26.4B1 Ex Order 26.4B1 continuously. Demand Ex Order 26.4B1 [redacted]." The RN signed a received date Ex Order 26.4B1 with an amount received of four and documentation of one Ex Order 26.4B1 being removed on Ex Order 26.4B1 with Ex Order 26.4B1 remaining. There was no corresponding prescription number on the handwritten label. The LPN stated that there were no other IPSCAR's in the binder for Ex Order 26.4B1 for Resident #162 and that the Ex Order 26.4B1 were removed when the pump signaled another bag was needed and the Ex Order 26.4B1 [redacted] removed from inventory. The LPN added that he thought the Ex Order 26.4B1 with the signature that the Ex Order 26.4B1 bag was removed from inventory on NJ Exec. Order 26 2 at 8:20 AM reflected the bag that was currently hanging but was unable to speak to any discrepancy in the inventory count. A review of the Narcotic & Controlled Drug Sign-In Sheet reflected that there were no	F 755	All Nursing Staff were in-service on how to properly fill out the declining form for the Ex Order 26.4B1 with a second nurse as a witness and properly destructed using the Drug Buster. PRN Manual Medication Administration Record Form was Created to reflect the Hanging and Removal of the IV MSO4 Via Pump. Registered Nurse will sign the PRN form upon hanging and Removing the Ex Order 26.4B1 from the pump and to write the Prescription number to ensure that all bags are accounted for. Used by Date will also be entered in the PRN Manual Form to ensure that performance of the solutions is sustained. All nurses were inserviced on the PRN Manual Medication Administration Record Form. 4. DON or designee will Randomly Audit one unit Narcotic Binder Once a week x 4 weeks, then monthly x2 months, then quarterly x 1 quarter to ensure that Ex Order 26.4B1 are destroyed with proper procedure. The DON or designee will audit one PRN Manual Medication Administration Record Once a week x 4 weeks, then monthly x2 months, then quarterly x 1 quarter Results of the Audit will be reported to the DON and Administrator and will be presented at the monthly QAPI meeting	

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F 755	Continued From page 19	F 755		

signatures for the incoming nurse and outgoing nurse for [NJ Exec. Order 26.4B1] and there was no indication that there was a discrepancy.

On 11/29/22 at 10:15 AM, the surveyor, with the Infection Preventionist(IP)/LPN and the LPN, observed Resident #162 in his/her room with a Ex Order 26.4B1 in use via a pump system. The resident stated that he/she was familiar with his/her medications and had been in control of all his/her medications prior to coming to the facility.

At that time, the surveyor, with the IP/LPN, observed the label of the Ex Order 26.4B1 was in use which revealed a prescription number that corresponded with the three of the four bags from the refrigerator.

On 11/29/22 at 10:19 AM, the surveyor interviewed the IP/LPN who stated that she thought when the Ex Order 26.4B1 were hung that date and time on the electronic medication administration record (EMAR) would correlate with the removal of the Ex Order 26.4B1 on the [redacted].

On 11/29/22 at 10:21 AM, the surveyor interviewed the Regional Clinical Nurse (RCN) in the presence of the IP/LPN and LPN regarding the Ex Order 26.4B1 that were found in the refrigerator for Resident #162 along with the two corresponding Ex Order 26.4B1s. The RCN and IP/LPN acknowledged that the Ex Order 26.4B1 with the provider pharmacy label indicating that there should be Ex Order 26.4B1 with the same prescription number had only Ex Order 26.4B1 in the refrigerator. In addition, the Ex Order 26.4B1 with a different prescription number corresponded to the handwritten Ex Order 26.4B1 by default since the

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F 755	Continued From page 20 handwritten Ex Order 26.4B1 had no prescription number to verify. The RCN, IP/LPN and LPN could not speak to the discrepancy. The RCN stated that he would have to notify the Director of Nursing (DON). On 11/29/22 at 12:26 PM, the surveyor interviewed the Registered Pharmacist (RP) from the provider pharmacy who stated that he was the IV RP and was unaware that there were any issues with the Ex Order 26.4B1 for Resident #162. The RP stated that Ex Order 26.4B1 was usually sent for controlled drugs with the same prescription number. The RP further explained that there would be Ex Order 26.4B1 per one Ex Order 26.4B1. The RP added that the nurses should be signing the Ex Order 26.4B1 for the date and time when a Ex Order 26.4B bag was removed from inventory. The RP verified that Ex Order 26.4B1 were delivered to the facility and received on Ex Order 26.4B1 with the same prescription number. The RP added that another delivery of Ex Order 26.4B1 were made on Ex Order 26.4B1 with a different prescription number. The RP also stated that it was possible that an Ex Order 26.4B1 for the Ex Order 26.4B1 delivery was not sent with the Ex Order 26.4B1 but if the facility had called and let him know then an Ex Order 26.4B1 would have been sent. In addition, the RP stated that if the facility was creating a handwritten Ex Order 26.4B1 then the prescription number should be on the label. The RP stated that possibly the Ex Order 26.4B1 was confusing because the Ex Order 26.4 was administered continuously, (meaning there was always a Ex Order 26.4 Ex Order hanging at all times so when one was finished the next had to be hung), but the nurses should still have been signing for the removal of a Ex Order 26.4B1 from inventory from the corresponding IPSCAR.	F 755		

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F 755	Continued From page 21 The surveyor reviewed the medical record for Resident #162. A review of the resident's Admission Record revealed diagnoses which included Ex Order 26.4B1 [redacted] A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26.4B1, reflected the resident had a brief interview for mental status (BIMS) score of Ex Order 26.4B1, indicating that the resident had an Ex Order 26.4B1. A review of the Order Summary Report reflected a physician's order (PO) dated Ex Order 26.4B1 for Ex Order 26.4B1 use Ex Order 26.4B1 supervised NJ Exec. Order 26:4.b.1 continuous via CADD pump. Administer Ex Order 26.4B1 continuous, Ex Order 26.4B1 push demand dose, NJ Exec. Order 26:4.b.1 lock interval." A review of the EMAR reflected the same PO dated [redacted] with nurses' initials for administration times of "Night" on Ex Order 26.4B1 and "Day 7" on Ex Order 26.4B1 Further review of the EMAR reflected the same PO dated Ex Order 26.4B1 with a discontinue date of Ex Order 26.4B1 had nurses' initials for the administration time of "Day 7 on Ex Order 26.4B1 In addition, the EMAR reflected the same PO dated Ex Order 26.4B1 with a discontinue date of Ex Order 26.4B1 with nurses' initials for the administration times of "Eve 3" and "Night" for Ex Order 26.4B1 and	F 755		

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F 755	Continued From page 22 "Day 7", "Eve 3", Night" for [redacted] and [redacted]. On 11/30/22 at 1:24 PM, the surveyor interviewed the RCN who provided two additional [redacted] for the [redacted]. The RCN stated that the [redacted] were all accounted for and had additional [redacted] but was unable to speak to what had happened. The RCN was also unable to speak to whether the EMAR corresponded with the [redacted] A review of the [redacted] additional [redacted] revealed the following: The [redacted] CAR reflected a label from the pharmacy provider that had the quantity filled was [redacted] containing [redacted] each with a signature that the RN signed as a received date of [redacted]. The "amount received" had [redacted] and in the lower left-hand corner was handwritten [redacted] bag." The prescription number on the label corresponded with the one of [redacted] that was stored in the [redacted] unit refrigerator. There was documentation that one [redacted] was removed from inventory on [redacted] at 1:47 PM with no ending balance of inventory noted. The [redacted] reflected a handwritten label for Resident #162 "[redacted] RX# [redacted]." at [redacted] continuously. Demand dose at [redacted]." The RN signed a received date [redacted] with an amount received of four and documentation of [redacted] removed from inventory on [redacted] and [redacted] with [redacted] bags remaining.	F 755		

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At that time, the RCN explained that the IPSCAR with the handwritten label indicating "RX# Ex Order 26.4B1 was inadvertently used as the prescription number but had corresponded to another number on the pharmacy provider label. The RCN was unable to speak to why there were several Ex Order 26.4B1 for the same prescription number or why there was handwritten Ex Order 26.4B1 being used.

On 11/30/22 at 1:48 PM the surveyor interviewed the DON who stated that he had accounted for all the Ex Order 26.4B1. The DON explained that the nurses had used separate Ex Order 26.4B1 for the removal of each Ex Order 26.4B1 and that was why the bottom left corner of the Ex Order 26.4B1 indicated Ex O Ex Order" and Ex Order 26.4B1." The DON stated that there was confusion with the documentation on the EMAR because the Ex Order 2 was a Ex Order 26.4B1 and therefore may have been the reason that the EMAR was not correlating with when the Ex Order 26.4 Ex Order 26 were removed from inventory.

At that time, the surveyor was provided by the DON the packing receipts from the provider pharmacy with the dates of delivery that corresponded to the number of Ex Order 26.4B1 received. The DON added that when the nurses received the Ex Order 26.4B1s, they had not received an Ex Order 26.4B1 from the provider pharmacy each time, so the nurses had created a handwritten Ex Order 26.4B1. The DON acknowledged that the handwritten Ex Order 26.4B1 had not included the prescription number and should not have been used. The DON stated that the additional signed Ex Order 26.4B1 for the Ex Order 26.4B1 were kept in his office and were not in the binder on the medication cart. The DON acknowledged that one Ex Order 26.4B1 per prescription would indicate the actual inventory and when the inventory was

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F 755	Continued From page 24 completed on 11/29/22 on the unit, the narcotic binder with the two Ex Order 26.4B1 for Ex Order 26.4B1 bags for Resident #162 had not accurately reflected the actual inventory and reconciliation. On 11/30/22 at 2:20 PM, the surveyor interviewed the DON in the presence of the survey team. The DON acknowledged that the EMAR had not correlated with the removal from inventory for each Ex Order 26.4B1. The DON stated that he would have to make sure that the nurses were signing for the removal of a Ex Order 26.4B1 on the Ex Order 26.4B1 and correspond that to the EMAR. On 12/2/2022 at 9:13 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that he was not familiar with the Ex Order 26.4B1 for the Ex Order 26.4B1. The CP acknowledged that the Ex Order 26.4B1 should correspond with the actual count of a controlled medication and the removal dates, times and signatures should indicated on the Ex Order 26.4B1 and should correlate with the medication administration on the EMAR. On 12/5/22 at 8:33 AM, the surveyor interviewed via telephone the RN who stated that she had signed for the receipt of the Ex Order 26.4B1. The RN had recalled that there were a couple times that she had received Ex Order 26.4B1 on different days. The RN stated that sometimes she had not received the Ex Order 26.4B1 from the provider pharmacy and had created a handwritten Ex Order 26.4B1. The RN added that she had completed one Ex Order 26.4B1 for each Ex Order 26.4B1 and put all the Ex Order 26.4B1 in the narcotic binder. The RN added that sometimes the provider pharmacy had sent one Ex Order 26.4B1 for the Ex Order 26.4B1. The RN was unsure of why both methods were used, but thought the inventory would still be accurate.	F 755		

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On 12/5/2022 at 12:48 PM, the survey team met with the facility administrative team. The DON stated that he was updating the forms for the Ex Order 26.4B1 to reflect an accurate count, removal from inventory and administration.

A review of the facility policy dated as revised April 2022 for, "Controlled Substance" provided by the DON reflected that the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. In addition, the policy reflected: "If the count is correct, a control sheet must be made for each substance. Do not enter more than one (1) prescription per page." Also, "Nursing staff must count controlled drugs 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 DON."

2. On 11/29/22 at 10:11 AM, the surveyor, with the LPN, observed an Ex Order 26.4B1 for Ex Order 26.4B1 and another Ex Order 26.4B1 for Ex Order 26.4B1 that were both for Resident #162. The Ex Order 26.4B1 reflected that Ex Order 26.4B1 Ex Order 26.4B1 were applied on Ex Order 26.4B1 Ex Order 26.4B1. There was no indication or signatures on the Ex Order 26.4B1 that the patches that were applied on Ex Order 26.4B1 were removed and wasted.

The LPN stated that Ex Order 26.4B1 of each dose was applied to the resident for a Ex Order 26.4B1 Ex Order 26.4B1 and the Ex Order 26.4B1 that were currently on the resident were applied on Ex Order 26.4B1. The LPN

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then stated that when the patches were removed the nurses were to sign the EMAR for removal and that was why the Ex Order 26.4B1 had not indicated the "Date removed & wasted", "Time removed & wasted" along with the nursing signatures for the Ex Order 26.4B1 that were removed.

On 11/29/22 at 10:19 AM, the surveyor interviewed the IP/LPN who stated that she thought the removal of the Ex Order 26.4B1ches was documented in the EMAR.

On 11/29/22 at 10:21 AM, the surveyor, with the RCN, observed the EMAR which revealed a nurses' initials documented for the removal of the Ex Order 26.4B1 for Resident #162. The RCN stated that the electronic system only allowed for one signature for the removal. The RCN acknowledged that there should be two nurses' signatures for the removal of a Ex Order 26.4B1 but was unable to speak to why there was only one signature for the removal on [redacted].

Ex Order 26.4B1

patch IPSCAR was supplied by the provider pharmacy, but the facility was responsible for the method of documentation for the removal of the patches. The RP added that the Ex Order 26.4B1 Ex Order 26.4B1 provides a section to document the removal, but the facility could utilize another system. The RP added that removal of a Ex Order 26.4B1h required the signature of a nurse and a witness because Ex Order 26.4B1 was a Ex Order 26.4B1.

On 12/2/2022 at 9:13 AM, the surveyor interviewed the CP who stated that when

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F 755	Continued From page 27 Ex Order 26.4B1 were removed there was to be signatures from two nurses for the removal and destruction of the Schedule II controlled drug. On 12/2/22 at 8:12 AM, the surveyor interviewed the DON who acknowledged that the facility policy for "Controlled Substance" that had been provided had not reflected how a controlled drug was to be destroyed and documented. The DON stated that all controlled drugs were to be destroyed or wasted in the presence of two nurses and the medication was to be placed in a drug disposal system used by the facility and both nurses were to sign the IPSCAR for the destruction. On 12/5/22 at 12:48 PM, the survey team met with the administrative team. The DON acknowledged that the removal of the Ex Order 26.4B1 Ex Order 26.4 required two nurses to sign for the removal and destruction and was in servicing the nurses on the correct method. A review of the facility policy dated as revised April 2022 for "Controlled Substance" provided by the DON reflected that the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Also, "Nursing staff must count controlled drugs 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 DON." NJAC: 8:39-29.2(a)(d), 29.4(k), 29.7(c)	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758		1/11/23

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F 758	Continued From page 28 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 29 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to monitor a.) specific target behaviors with quantifiable data for a resident on NJ Exec. Order 26:4.b.1 [redacted] and ensure b.) non-pharmacological interventions were attempted prior to administering Ex Order 26.4B1 [redacted] medication) as a one-time dose for a resident with Ex Order 26.4B1. This deficient practice was identified for 1 of 5 residents, (Resident #105) reviewed for unnecessary medication use. This deficient practice was evidenced by the following: On 12/1/22 at 11:09 AM, the surveyor observed Resident #105 out of bed seated at a table with two other residents and working a Ex Order 26.4B1. The activity staff member spoke in EX Order 26.4B1 when she conversed with the resident. The surveyor reviewed the medical record for Resident #105. A review of the Admission Record reflected that the resident was admitted to the facility on Ex Order 26.4B1, with diagnoses which included	F 758	1. Resident # 105 was referred to Psychiatrist for consult and target behavior for utilization of [redacted] medications were identified as well as list of non-pharmacological interventions and a plan of care on how to manage resident's behavior. 2. All Residents that is on [redacted] medication have the potential to be affected by the same deficient practice. 3. Behavior Monitoring Documentation Features in PCC was enabled to ensure that nurses will be able to check off the behavior that the resident is exhibiting, provide non-pharmacological intervention and Document outcome of interventions before providing pharmacological interventions. This will also generate a Quantitative summary of how often/frequent the resident is exhibiting the targeted behavior. this will generate every shift.	

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F 758	Continued From page 30 unspecified EX Order 26.4B1 [redacted].	F 758	All targeted behavior of residents on EX Order 26.4B1 medications were identified and added to their Comprehensive Plan of care. Behavior Documentation in PCC will be in-serviced by the DON or designee to all nursing staff (Nurses through EMAR and CNA Through Point of Care) to ensure compliance by 1/11/23. 4. DON or designee will Audit Behavior Documentation in 2 charts once a week X 4 weeks and monthly X 3 Months. Results of the audit will be reported to the Administrator at the monthly QAPI meeting.	

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated EX Order 26.4B1 reflected that the resident had a brief interview for mental status (BIMS) score of EX Ord, indicating that the resident had EX Order 26.4B1. Review of section E for behavior indicated that the resident had NJ Exec. Order 26:4.b.1 in the last seven days that impacted care.

A review of the Order Summary Report reflected a Physician's Order (PO) dated EX Order 26.4B1 for EX Order 26.4B1 [redacted]

Further review of the Order Summary Report reflected a PO dated EX Order 26.4B1, for EX Order 26.4B1 [redacted]

A review of the initial EX Order 26.4B1 Evaluation dated EX Order 26.4B1, reflected that the resident had a history of EX Order 26.4B1 with EX Order 26.4B1 and was admitted to the facility after EX Order 26.4B1 for EX Order 26.4B1 " and EX Order 26.4B1 EX Order 26.4B." The evaluation indicated that the resident was EX Order 26.4B1" with a EX Order 26.4B1 and "appropriate" EX Order 26.4 and EX Order 26.4B1 speech. The evaluation further indicated that the resident was on EX Order 26.4B1. The EX Order 26.4B1 diagnoses indicated EX Order 26.4B1 with EX Order 26.4B1, EX Order 26.4B1 EX Order 26.4B1, and rule out EX Order 26.4B1 The plan indicated to always consider supportive

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interventions including support/reassurance, comfort measures, reduced stimulation, expression of feelings, family involvement; continue current medication regimen benefit outweigh risks; monitor for changes in behavior/mood. Notify psych; will continue to follow; and to change diagnosis for EX Order 26.4B1 to EX Order 26.4B1 and rule out EX Order 26.4B1 EX Order 26.4B1 r. The EX Order 26.4B1 evaluation did not reflect a diagnosis of EX Order 26.4B1 .

A review of the resident's individualized Comprehensive Care Plan initiated on EX Order 26.4B1 indicated that the resident had the potential to be EX Order 26.4B1 " related to EX Order 26.4B1 Interventions included to analyze key times, places, circumstances, triggers, and what de-escalates behavior and document.

A review of the EX Order 26.4B1 Monthly Review Assessment dated EX Order 26.4B1 indicated a target behavior(s) for 'NJ Exec. Order 26:4.b.1 " The number of behavioral episodes or the quantitative measure of episodes indicated "0."

A review of the Ex Order 26.4B1 Monthly Review Assessment dated Ex Order 26.4B1 indicated "yes" for target behaviors. There was no specific target behaviors identified with quantifiable data documented in the assessment.

A review of the Ex Order 26.4B1 "Behavior Monitoring and Interventions" provided by the Director of Nursing, indicated "NB" (no behaviors). Further review of the behavior monitoring, and interventions revealed that on NJ Exec. Order 26:4.b.1 of various shifts indicated "-97" (not

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F 758	Continued From page 32 applicable). The DON stated that the Certified Nursing Assistants fill out this section in the electronic medical record. A review of the electronic Progress Note (ePN) dated [redacted] and timed at 10:04 AM, indicated that the resident was [redacted], call out to MD [medical doctor]." Further review of the [redacted] PN's reflected that the MD called back and ordered [redacted] as a one time dose. There was no documented evidence of non-pharmacological interventions prior to the administration of [redacted] Review of the Physician History and Physical ePN dated [redacted], reflected that the resident was hospitalized due to "[redacted]" Review of a "Late Entry" ePN dated [redacted] timed at 11:28 AM and titled "Care Plan Meeting" reflected that the resident was [redacted] e at home and "does not currently have [redacted] noted ...[redacted] y daily." Review of the ePN dated [redacted], indicated that the "resident observed [redacted] ngoing activities." A review of the [redacted] electronic Medication Administration Record (eMAR) reflected to "monitor side effects for an [redacted] Resident is on [redacted] every shift CD = Code Description. USE LEGEND ON NURSES CART AND NURSES STATION." On 12/2/22 at 11:30 AM, the surveyor inquired	F 758		

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F 758	Continued From page 33 about the legend kept on the nurse's cart or at the nurses station. There was no legend provided. On 12/2/22 at 12:01 PM, the surveyor interviewed a Certified Nursing Assistant (CNA#1) who was familiar with Resident #105. The CNA#1 stated that "sometimes" the resident was a little [redacted] and "sometimes" the resident would [redacted] but not to much and "sometimes" during the 3-11 shift, the resident would [redacted] y but the resident had [redacted]. On that same day, a short time later, the surveyor interviewed CNA #2 who stated she took care of Resident #105. She stated the only problem was that if the resident needed to [redacted] then he/she would need the [redacted]. She further stated that "sometimes" the resident would [redacted] but not all the time and was easily redirected. She confirmed that the resident was [redacted] and was easily redirected. On 12/2/22 at 9:15 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1) who completed the [redacted] Monthly Review Assessment dated 10/1/22. LPN #1 stated that the target behaviors were discussed with the [redacted] nurse practitioner and confirmed that there should have been specific target behavior(s) monitored for the resident. On 12/2/22 at 12:17 PM, the surveyor interviewed LPN #2 who completed the [redacted] Monthly Review Assessment dated [redacted] LPN #2 could not speak to what a target behavior was or what the target behavior(s) were for Resident #105. He further stated that if the resident had no behaviors, then the medication was working.	F 758		

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F 758	Continued From page 34 On 12/5/22 at 12:52 PM, the surveyor interviewed the DON in the presence of the survey team. The DON stated that the electronic medical record system did not allow the nurses to enter target behavior(s) into the system. The facility was going to update the process to include target behaviors for residents on psychotropic medications. He further stated that the monthly behavior charting did not include target behaviors. He stated that when the resident exhibited behaviors it was documented in the progress notes, but it wasn't a quantitative monthly summary. A review of the facility's Behavioral Assessment, Intervention and Monitoring Policy updated 10/2022, included that targeted and individualized interventions for the behavioral and/or psychosocial symptoms; specific and measurable goals for targeted behaviors and how the staff will monitor for effectiveness of the interventions. The policy also reflected that non-pharmacological approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. In addition, when medications are prescribed for behavioral symptoms, documentation will include "specific target behaviors and expected outcomes, duration, monitoring for efficacy and adverse consequences; and plans for gradual dose reduction."	F 758		
F 812 SS=D	NJAC 8:39-27.1(a),29.4(n) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		1/6/23

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F 812	Continued From page 35 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to sanitize, store, and maintain kitchen equipment to prevent microbial growth. This deficient practice was identified during the initial tour of the kitchen and was evidenced by the following: On 11/28/22 at 9:55 AM, the surveyor observed the can opener to have copious amounts of food debris and metal fragments on the blade and the body of the unit. On 11/28/22 at 10:00 AM, the surveyor observed copious amounts of accumulated food debris under the range burners without a removable tray to catch, dispose of and clean properly. On 11/28/22 at 10:10 AM, the surveyor observed the double stacked convention oven to have	F 812	1. : The Can opener was replaced on 11/28/22. The Range Burners and Double oven were cleaned on 11/28/22. A tray for the range was obtained on 12/2/22. 2. All residents can be affected 3. Can opener cleaning has been added to the daily kitchen cleaning process. A regular cleaning schedule was created for the range and oven. 4. . the Food Service Director will audit the Can Opener weekly x 4 weeks, then monthly x 3 months for cleanliness. The FSD will also audit the cleaning logs weekly x 4 and then monthly x3 months to	

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 _____	12/09/2022

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 812	Continued From page 36 copious amounts of brown matter on the internal glass doors and interior of the unit. During an interview on 11/28/22 at 10:42 AM, the Food Service Director (FSD), stated that it was his first day at the facility and he was unsure of the current cleaning schedule and policies. During an interview on 11/28/22 at 10:50 AM, the Regional Food Service Director (RFSD) stated the can opener should be cleaned with every meal, and washed through the wash cycle of the dish washer. The RFSD observed the can opener in the presence of the surveyor. The RFSD stated that daily cleaning to the can opener was not performed by the kitchen staff, there was no schedule in place for cleaning the can opener and there was no accountability of a cleaning schedule for the can opener. On 12/01/2022 at 1:00 PM, the surveyor discussed the findings with the facility Licensed Nursing Home Administration (LNHA). A review of the facilities policy titled, "Oven Cleaning and Sanitation Policy," reviewed/revised on 10/12/2021, revealed that ovens would be cleaned as needed based upon grease or soil buildup and weekly as a minimum standard practice. The facility's, "Oven Cleaning and Sanitation Policy" further reflected visible build up or debris must be cleaned immediately. A review of the facilities policy titled, "Can Opener Cleaning Policy," reviewed 6/2021, revealed that the kitchen staff would ensure that the manual can-opener would be in good operating condition, with no visible food debris buildup.	F 812	ensure that oven and range burners is cleaned on schedule. The results of the audits will be presented to the monthly QAPI meetings.	

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	315015	A. BUILDING _____ B. WING _____	12/09/2022

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F 812	Continued From page 37 NJAC 8:39-17.2(g)	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		1/6/23

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 _____	12/09/2022

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F 842	Continued From page 38 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a complete, accurate, readily accessible, and systematically organized medical record. This deficient practice was identified for 1 of 24 residents, (Resident #38) reviewed for complete and accurate medical records and was evidenced by the following:	F 842	1. Resident # 38 [redacted] consult was obtained from the [redacted] office and was placed on her Medical Records on [redacted] 2. All Residents that required to be seen by	

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 _____	12/09/2022

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 842	Continued From page 39 On 11/28/2022 at 10:32 AM, the surveyor observed Resident #38 lying in bed. The surveyor interviewed the resident. During the interview the surveyor observed that the resident had Ex Order 26.4B1 [redacted] During an interview on 12/02/2022 at 10:45 AM, the A-wing, Licensed Practical Nurse (LPN), stated that the resident would allow staff to perform Ex Order 26.4B1 care and Ex Order 26.4B1, but if staff took too long performing the care, the resident would yell. The LPN also stated that the resident did not wear Ex Order 26.4B1 During the interview the surveyor asked what the facility process was to obtain Ex Order 26.4B1 services for the resident? The LPN stated that if facility staff identified the resident needed a Ex Order 26.4B consult, she would notify the Unit Manager (UM), the UM would notify the Ex Order 26.4B1 via e-mail to schedule an appiontment, and then document the concern and need for the Ex Order 26.4B consult in the resident's medical record. During an interview on 12/02/2022 at 10:41 AM, the A-Wing Registered Nurse/Unit Manager (RN/UM) stated she had not requested a Ex Order 26.4B consult for Resident #38 because there had not been issues with the resident's Ex Order 26.4B1. The RN/UM further stated that the resident ate all his/her food and had not complained o Ex Order 26. The surveyor asked her to explain the facility process to initiate a consult or annual Ex Order 26.4B visit. The RN/UM stated that the process was she would e-mail the Ex Order 26.4B1 for a consult visit and the resident would be placed on an examination list which was distributed to staff at the nursing station. At that time, the RN/UM called the contracted Ex Order 26.4B office to see if Ex Order 26.4B services	F 842	a Dentist have the potential to be affected. 3. In-service to all nurses that post consult notes are to be written in resident charts, and that consults are to be uploaded into residents charts via the misc tab in PCC. 4. The DON and Designee will audit 2 charts weekly x1 month, then 3 chart monthly X3 Months To ensure that consults are place in the chart and the nurses have a progress notes written related to and outcome of the consult. Results of the audit will be reported to the administrator and will be discuss in monthly QAPI.	

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F 842	Continued From page 40	F 842		

had been performed for Resident #38 because the hybrid medical record did not reflect that a [redacted] visit was made. The contracted [redacted] office stated that Resident #38 had an annual [redacted] exam on [redacted]. The RN/UM requested a faxed copy of the consult to be placed in the resident's medical record.

During an interview on 12/05/22 at 1:08 PM, the Director of Nursing (DON) stated, "When the resident was seen by a [redacted] the [redacted] would provide the facility with the consult documentation and they would provide the consult and exam to the facility and upload it into the resident's electronic medical record. If it was a hard copy, the copy would be placed in their medical record."

During an interview on 12/05/22 at 1:12 PM, the Infection Preventionist Licensed Practical Nurse (IP/LPN) stated, "a list will be provided to the UM, given to aides so they can get the residents ready to see the [redacted] On the day the [redacted] comes, we print the list, the aides and floor nurses will know. The [redacted] will then go to the resident's room and the [redacted] will evaluate the resident in their room." The IP/LPN further stated that once the [redacted] had completed their visit with the resident and documented the care provided, they would upload the document into the residents electronic medical record.

The surveyor reviewed the hybrid medical record for Resident #38.

A review of the Admission Record reflected that Resident #38 was admitted to the facility on [redacted] with a diagnosis which included but were not limited to a [redacted]

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F 842	Continued From page 41	F 842		

EX Order 26.4B1 [redacted]

A review of the residents annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated EX Order 26.4B1, reflected the Brief Interview for Mental status Score (BIMS) was [redacted] out of 15 indicating the residents' cognitive skills for daily decision making were EX Order 26.4B1

A review of the resident's progress notes revealed that there was not a nursing note created for the [redacted] visit on [redacted]

A review of the facility's policy titled, "Physician Services Policy Statement," updated 10/2022, indicated physician visits, frequency of visits, emergency care of residents, and consultative services shall be made available from community-based consultants or from local hospital or medical center.

A review of the facility's policy titled, "Dental Services policy statement," updated on 10/2021, revealed all dental services provided are recorded in the resident's medical record. A copy of the resident's dental record is provided to any facility to which the resident is transferred.

A review of the facilities policy titled, "Dental Service Agreement," signed and dated on 10/6/2021, revealed responsibilities of Facility: #2,

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F 842	Continued From page 42 Document in the nursing notes each dental visit per patient. A review of the facility's policy titled, "Retention of Medical Records Policy Statement" revealed, medical records shall be retained by the facility in accordance with the current applicable laws. NJAC 8:39-35.2 (d)(5)	F 842	-	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061217	A. BUILDING: _____ B. WING _____	12/09/2022

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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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in CNA staffing for 14 of 14-day shifts reviewed. Findings include: 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, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1. No residents were identified 2.. The deficient practice has the potential to affect all residents residing in the facility. 3 Bonuses are offered as needed for open shifts. Nursing staff has been re-educated on the call out and lateness policy by DON or designee. advertisements signs for open CNA positions are placed in front of the building. The facility is recruiting on multiple employment search engines and multiple social media platforms for CNA's, and has a dedicated recruitment	1/6/23

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

Electronically Signed | 01/02/23

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 _____	12/09/2022

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S 560	Continued From page 1 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. A review of the "Nurse Staffing Report" completed by the facility for the weeks of (11/13/2022 to 11/19/2022 and 11/20/2022 to 11/26/2022) for the 12/07/2022 Standard survey revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -11/13/22 had 10 CNAs for 120 residents on the day shift, required 15 CNAs. -11/14/22 had 11 CNAs for 120 residents on the day shift, required 15 CNAs. -11/15/22 had 9 CNAs for 117 residents on the day shift, required 15 CNAs. -11/16/22 had 10 CNAs for 117 residents on the day shift, required 15 CNAs. -11/17/22 had 12 CNAs for 117 residents on the day shift, required 15 CNAs.	S 560	team.Reviewed Facility Staffing Agency contracts, additional Agency Contracts under review. 4. The DON/Designee will conduct weekly x 4 weeks C.N.A. staffing schedule audits. Then quarterly x 1 quarter. • The DON/Designee will report audit findings to the Administrator, and will be presented at the monthly QAPI meetings.	

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 _____	12/09/2022

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S 560	Continued From page 2 -11/18/22 had 10 CNAs for 117 residents on the day shift, required 15 CNAs. -11/19/22 had 11 CNAs for 117 residents on the day shift, required 15 CNAs. -11/20/22 had 10 CNAs for 117 residents on the day shift, required 15 CNAs. -11/21/22 had 11 CNAs for 117 residents on the day shift, required 15 CNAs. -11/22/22 had 11 CNAs for 117 residents on the day shift, required 15 CNAs. -11/23/22 had 13 CNAs for 117 residents on the day shift, required 15 CNAs. -11/24/22 had 14 CNAs for 117 residents on the day shift, required 15 CNAs. -11/25/22 had 11 CNAs for 116 residents on the day shift, required 14 CNAs. -11/26/22 had 10 CNAs for 116 residents on the day shift, required 14 CNAs. During an interview with the surveyor on 12/06/22 at 10:02 AM, the Staffing Coordinator (SC) stated that her job description was with human resources, payroll, and staffing. The SC stated that she staffed the facility according to the staffing requirement for every unit and adjusted stafffing according to the facility's census and admissions. The SC acknowledged the minimum staffing requirements for nursing homes and added that she staffed the facility daily to meet the requirements. The SC further stated that she will plan staffing ahead for a month, but with call outs it was difficult to meet the required staffing numbers. The SC stated that both the Director of Nursing and Administrator were notified and aware when the facility was not meeting the required staffing ratios. The SC told the surveyor that the facility utilized two satffing agency to fill both CNA and nurse positions.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315015 Y1	A. Building B. Wing Y2	3/8/2023 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 F0637	Correction	ID Prefix F0658	Correction	ID Prefix F0684	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25	Completed
LSC	01/06/2023	LSC	01/06/2023	LSC	01/06/2023
ID Prefix F0755	Correction	ID Prefix F0758	Correction	ID Prefix F0812	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	01/06/2023	LSC	01/11/2023	LSC	01/06/2023
ID Prefix F0842	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/06/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
12/9/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061217	A. Building B. Wing	3/8/2023

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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/06/2023	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	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 12/9/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. BUILDING **01** B. WING _____	**12/09/2022**

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 12/08/22 and 12/09/22, 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 in 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 generator diesel fueled unit.The generator is stated to approximately 50% 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. At the time of the survey the census was 123. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101	K 211		1/2/23

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

Electronically Signed | 01/02/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 211	Continued From page 1 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 12/09/22, in the presence of the Regional Director (RD) and Maintenance Director (MD), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice occurred for 9 of 9 fire doors observed, and was evidenced by the following: At 09:45 AM, the MD was asked to provide the annual testing requirements for fire door assemblies in accordance with NFPA 80. The MD stated that currently the facilty did not have documentation on fire door assemblies. The Administrator was informed of the finding's at the Life Safety Code exit conference held on 12/09/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	1. 9 of the 9 Fire Door assembly were inspected on 12/12/22 to ensure all NFPA standards were being met. 2. All residents can be affected 3. The maintenance director was in service on yearly door assembly inspections requirements on 12/9/22 by the administrator. The Maintenance Director will add this inspection to the yearly inspection calendar 4. . Maintenance Director or Designee is responsible for the completion of the annual fire door inspection log. Results of the annual fire door inspection log will be presented to the Administrator at monthly QAPI committee for review and recommendation.	

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K 291	Continued From page 2	K 291		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/08/22, in the presence of the Regional Director (RD) and Maintenance Director (MD), it was determined that the facility failed to provide a battery back-up emergency light above the emergency generator (2) transfer switches independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 2 of 2 transfer switches and was evidenced by the following: At 01:07 PM, the surveyor in the presence of the (RD) and (MD), observed 2-transfer switches, ATS-1 (outside by the generator) and ATS-2 (inside basement electrical room) were not equipped with battery back-up emergency lighting. The RD and MD both confirmed the findings at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit on 12/09/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	1. Emergency independent 90 minute battery lighting was installed at the interior transfer switch on 12/28/22. Installation is scheduled with an outside electrician for lighting for the exterior transfer switch for 1/20/23 2. All residents can be affected. 3. The maintenance director was educated by the administrator on 12/9/22 that transfer switch locations require 90 minutes of backup lighting. Monthly testing of the emergency light has been added to the monthly maintenance checklist 4. the maintenance Director or designee will audit monthly on the function of backup lighting at both ATS locations for 12 months. With results presented at monthly QAPI meeting	1/20/23
K 293 SS=E	Exit Signage CFR(s): NFPA 101	K 293		1/6/23

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K 293	Continued From page 3 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 observations and interviews conducted on 12/08/22 and 12/09/22, in the presence of the Maintenance Director (MD) and Regional Director (RD), it was determined that the facility failed to: a.) provide one exit sign that included a indicator showing the direction of travel, where the direction of travel to reach the nearest exit, in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. 2), and b.) properly identify doors, with a sign on a door, which is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall have a "no exit" sign and provide directional exit signs in accordance with NFPA 101, 2012 edition, section 19.2.10.1 and 7.10. The deficient practice was identified for 2 of 28 exit signs observed and was evidenced by the following: 1. On 12/08/22 at 11:11 AM, the surveyor, RD and MD, observed in the B-wing exit to the exit/egress door in the corridor was observed to have the illuminated exit arrow indicator on the sign pointing in the opposite direction.	K 293	1. The signage in b- wing was changed to indicate the correct direction to egress on 12/9/22. The signage on the B wing patio door was updated to: NO FIRE EXIT on 12/9/22 2. All residents can be affected by this. 3. The maintenance director will add fire exit signage inspections to his quarterly maintenance checklist. 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 293	Continued From page 4 2. On 12/09/22 at12:10 PM, the surveyor, RD and MD, observed that the B-unit dayroom # 8 door leading to the patio, was not provided with an "no exit" sign. The patio was not indicated on the evacuation plan as an exit. The findings were verified by the RD and MD at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/09/22. NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. NJAC 8:39-31.2(e)	K 293		
K 321 SS=E	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	K 321		1/6/23

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K 321	Continued From page 5 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: Based on observation and interview on 12/08/22, in the presence of the Regional Director (RD) and Maintenance Director (MD), it was determined that the facility failed to provide and maintain self-closing device on doors to hazardous area in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in 2 of 10 hazardous storage areas in the facility and was evidenced by the following: 1. At 12:19 PM, the surveyor, RD & MD observed in the currently closed D-unit that the D-4 room was storing hazardous cardboard boxes approximately 20 plus boxes and six plastic red bins. The room was greater than 50 square feet in size and required an auto-close device installed on the door. 2. At 12:32 PM, the surveyor, RD & MD observed in the patient storage room that combustible cardboard boxes were being stored. The room was greater than 50 square feet in size and required an auto-close device installed on the door. The RD and MD confirmed that hazardous	K 321	1. Room D-4 was emptied of all storage items on 12/13/22. An auto closure was installed on the patient storage room on 12/29/22 2. All residents can be affected by this 3. The Maintenance director was in serviced by the administrator about the requirement for storage areas to have auto closures on 12/9/22. Storage area auto closures inspections will be added to the monthly preventative maintenance schedule. 4. the Maintenance Director or designee will audit 2 storage areas weekly x4 then monthly times 2 then quarterly x2 to ensure auto closure is in place. With results reported to the QAPI committee that meets monthly.	

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K 321	Continued From page 6 storage areas must have a door with a self-closing device. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 12/09/22. NJAC 8:39-31.2(e)	K 321		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/08/22, in the presence of the Regional Director (RD) and Maintenance Director (MD), it was determined that the facility failed to provide fire alarm notification by audible and visible signals for one of one enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1,	K 341	1. Horn/Strobe installation for D wing courtyard was completed on 1/31/2023. 2. All residents can be affected by this 3.	1/31/23

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K 341	Continued From page 7 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: At 12:20 PM, the surveyor observed in the enclosed D-patio courtyard, no evidence of a fire alarm notification (horn/strobe) was observed. An interview was conducted during the observation with the RD and MD who both confirmed that the D-patio enclosed courtyard was not provided with a horn/strobe, tied into the fire alarm system. The Administrator was notified of the findings at the Life Safety Code exit conference on 12/09/22. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341	The maintenance director was in-serviced on the requirement for horn/strobe in closed in exterior locations. . And a quote and installations is scheduled 4. the maintenance director will include the horn/stobe inspection to the fire drill checklist. this audit will be done monthly x3 months, then quarterly x 2 quarters. The results will be submitted to the QAPI committee. The QAPI committee meets monthly.	
K 353 SS=E	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	K 353		1/6/23

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K 353	Continued From page 8 c) Water system supply source 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 observation and interviews on 12/08/22, in the presence of the Regional Director (RD) and Maintenance Director (MD), it was determined that the facility failed to: a.)maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated and b.) maintain all parts of their automatic fire sprinkler system in optimal condition as evidenced by the following: in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. 1. At 12:00 PM, the surveyor observed in the B-wing porter closet, that two ceiling tiles were missing in place. The tiles were approximately 2 feet (') x 4' and 1' x 2' in size. 2. At 12:18 PM, the surveyor observed in the laundry room, that in back of the three commercial clothes dryers, one of one fire sprinkler heads were dirty with a coating of lint on the frame and fusible link. The RD and MD, confirmed the above findings during the observations. The Administrator was informed of the findings at the Life Safety Code Exit Conference on	K 353	1. The two tiles in the ported closet was replaced on 12/9/22. The sprinkler head in the laundry was cleaned on 12/9/22 2. All residents have the potential to be affected by this practice 3. The maintenance director was in service on the requirement for ceiling tiles to be in place and in good condition, as well as the requirement for clean sprinkler heads on 12/9/22. Ceiling tile inspections and sprinkler head inspections will be added to the monthly preventative maintenance logs. 4. the maintenance director or designee will do 5 random Ceiling tile audits weekly x 4 then monthly x 2 then quarterly x3. The MD or designee will do 5 random sprinkler head audits x 4 weeks, then monthly x2 months. All reports will be presented to the administrator at the monthly QAPI meetings.	

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K 353	Continued From page 9 12/09/22. NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1.	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In	K 363		3/8/23

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

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K 363	Continued From page 10 sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/08/22, in the presence of the Regional Director (RD) and Maintenance Director (MD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was further identified in 9 of 40 resident room doors observed and was evidenced by the following: During the building tour from 9:15 AM to 3:00 PM, the surveyor, in the presence of the RD and MD toured the facility and observed the following: Resident Room doors: A-10 loose hardware top 1/2 inch (") gap. A-24 loose hardware top 1/2" gap. A-31 rubs into the door frame. B-4 will not latch. C-2 rubs into the door frame. C-3 top of the wooden door is warped leaving approximately 1/2" opening. C-18 loose hardware. C-21 top of the wooden door is warped leaving approximately 1/2" opening.	K 363	1. Doors A-10, A-24, A-31, B-4, C-2, C-3, C-18, C-21 and C-24 were assessed for repair on 12/29/22. These doors were designated that they should be replaced. A quote was obtained on 12/30/22 for replacement doors. They will be installed upon delivery. to date, these custom doors have been ordered, but have not yet been delivered. A Time Limited Waiver will be filled. expected delivery is 3/8/2023, with installation scheduled for the same day. 2. All residents can be affected by this 3. the maintenance Director was inserviced by the administrator on the proper fitting and closure of corridor doors. Corridor door inspections will be added to the monthly preventative maintenance schedule. All corridor doors will be assessed yearly for hardware, warping and ability to resist the passage of smoke. 4. the maintenance director will do 5 random door audits monthly x 3 months	

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 _____	**12/09/2022**

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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K 363	Continued From page 11 C-24 top of the wooden door is warped leaving approximately 1/2" opening. At the time of observations, the surveyor interviewed the RD and MD, who confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 12/09/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	with the results reported to the QAPI committee. The QAPI committee meets monthly.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, on 12/08/22, in the presence of the Regional Director (RD) and Maintenance Director (MD), it was determined that the facility failed to provide	K 374	1. Astragals have been ordered for Doors at A-1, A-14, A-20, B-4, B-14, B-24 and B-20 on 1/2/23 and will be installed on delivery.	2/1/23

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K 374	Continued From page 12 smoke barrier wall doors that completely closed to resist the passage of smoke, flame, or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1. This deficient practice was observed for 8 of 9 sets of double smoke doors observed and tested for closure and was evidenced by the following: 1. At 10:34 AM, the surveyor observed that the A-wing set of double smoke doors by resident room A-1, when released from the magnetic hold-open device and the two doors fully closed, there was a gap approximately 1/4 inch in size, compromising the integrity of the smoke zone. 2. At 10:41 AM, the surveyor observed that the A-wing set of double smoke doors by resident room A-14, when released from the magnetic hold-open device and the two doors fully closed, there was a gap approximately 1/4 inch in size, compromising the integrity of the smoke zone. 3. At 10:34 AM, the surveyor observed that the A-wing set of double smoke doors by resident room A-20, when released from the magnetic hold-open device and the two doors fully closed, there was a gap approximately 1/4 inch in size, compromising the integrity of the smoke zone. 4. At 11:41 AM, the surveyor observed that the A-wing set of double smoke doors by resident room B-4, when released from the magnetic hold-open device and the two doors fully closed, there was a gap approximately 1/4 inch in size, compromising the integrity of the smoke zone. 5. At 11:54 AM, the surveyor observed that the	K 374	New Auto closures have been ordered on 12/29/22 for the door at C-24, and will be installed upon delivery. Astreagals were installed by 1/15/2023. Auto Closures were installed on 2/1/23. 2. All residents can be affected. 3. the maintenance Director was Inserviced on 12/9/22 on the requirements of smoke barriers by the administrator . A yearly audit was added to the Barrier door inspection to include inspecting for full closure of barrier doors. . 4. the Maintenance Director will complete a monthly audit of a minimum of 2 barrier doors monthly x 3 months with results submitted quarterly to the QAPI committee. the QAPI committee meets monthly.	

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	315015	A. BUILDING **01** B. WING _____	**12/09/2022**

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K 374	Continued From page 13 A-wing set of double smoke doors by resident room B-14, when released from the magnetic hold-open device and the two doors fully closed, there was a gap approximately 1/4 inch in size, compromising the integrity of the smoke zone. 6. At 12:34 PM, the surveyor observed that the A-wing set of double smoke doors by resident room B-20, when released from the magnetic hold-open device and the two doors fully closed, there was a gap approximately 1/4 inch in size, compromising the integrity of the smoke zone. 7. At 12:44 PM, the surveyor observed that the C-wing set of double smoke doors by resident room B-24, when released from the magnetic hold-open device and the two doors fully closed, there was a gap approximately 1/4 inch in size, compromising the integrity of the smoke zone. 8. At 01:10 PM, the surveyor observed that the C-wing set of double smoke doors by resident room C-24, when released from the magnetic hold-open device, one of the two doors would not fully close, leaving a gap approximately 1/2", compromising the integrity of the smoke zone. An interview was conducted with the RD and MD, during the observations, where they stated and confirmed that the smoke doors must fully close and resist the passage of smoke, flames, or gases during a fire. The Administrator was informed of the findings at the Life Safety Code exit conference on 12/09/22.	K 374		
K 918 SS=F	NJAC 8:39-31.2(e) Electrical Systems - Essential Electric Syste	K 918		2/24/23

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K 918	Continued From page 14 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/08/22,	K 918	1.	

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K 918	Continued From page 15 in the presence of the RD and MD, it was determined that the facility failed to ensure a remote manual stop station for one of one generator's and installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: At 1:05 PM, the surveyor, RD and MD observed the exterior generator. There was no remote manual stop station observed remotely outside the area of the generator location. An interview was conducted during the time of the observation with the MD, who confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation, located remotely outside the area of the enclosure housing the prime mover. The Administrator was informed of the findings at the Life Safety Code exit conference held on 12/09/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	Installation of a remote push stop has been ordered from electrician, and is currently waiting on parts for installation. Installation was completed on 2/22/23. 2. : All residents can be affected 3. the maintenance director was inserviced on 12/12/22 on the requirement for a remote stop switch for transfer switches. Remote push stop will be installed, Maintenance Director will check for function during quarterly preventative maintenance. 4. Outside vendor will audit function during yearly test. This audit will be done yearly. Maintenance Director or designee will submit the report to the QAPI committee. The QAPI Committee meets monthly.	

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	3/8/2023 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 K0211	01/02/2023	LSC K0291	01/20/2023	LSC K0293	01/06/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	01/06/2023	LSC K0341	01/31/2023	LSC K0353	01/06/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	03/08/2023	LSC K0374	02/01/2023	LSC K0918	02/24/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
12/9/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO