STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315136	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

Complaint #: NJ168497, NJ166056, NJ166064, NJ165600, NJ165502, NJ165128, NJ162691, NJ161796, NJ161294, NJ154045

Survey Dates: 05/21/24 through 05/30/24

Survey Census: 104

Sample Size: 21

Supplemental Residents: 17

A Recertification and Complaint survey was conducted at Complete Care at Shrewsbury from 05/21/2024 through 05/30/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities.

During the survey a finding which constituted Immediate Jeopardy (IJ) was identified under 42 CFR 483.25 F 600 as the facility failed to ensure adequate supervision of Resident #60 to prevent potential [NJ Ex Order 2] to other residents by Resident #60 and prevent [NJ Ex Order 2] to Resident #60 by other residents.

Record review revealed that Resident #60 was admitted to the facility on [NJ Ex Order 26.4(b)(1)] and resided on an [NJ Ex Order 26.4(b)(1)] unit. Additionally, s/he had diagnoses including, but not limited to moderate [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)].

Review of the [NJ Ex Order 26.4(b)] Quarterly Minimum Data Set (MDS) Assessment revealed the resident had a Brief Interview for Mental Status (BIMS) score of [NJ] out of 15 indicating his/her [NJ Exec Order 26.4(b)] was

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

Electronically Signed | 06/21/2024

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

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F 000	Continued From page 1 NJ Ex Order 26.4(b)(1). Review of the electronic medical record for Resident #60 revealed that on several dates and times the resident NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 into NJ Ex Order 26.4(b)(1) lying on their beds despite initiating a Care Plan for NJ Ex Order 26.4(b)(1) into NJ Ex Orde on NJ Ex Order 26.4(b)(1). On NJ Ex Order 26.4(b)(1), Resident #60 NJ Ex Order 26.4 a resident's NJ Ex Orde and NJ Ex Order 26.4(b)(1). No NJ Ex Order 26 were noted. Resident #60 was sent to the hospital for an evaluation and upon returning from the hospital Resident #60 NJ Ex Order 26.4(b)(1) into NJ Ex Order 26.4(b)(1). A Partial Extended Survey was initiated after the deficiency was identified at the IJ/SQC (Substandard Quality of Care) level. The U.S. FOIA (b) (6) was informed of the Immediate Jeopardy and was provided with the Immediate Jeopardy template on 05/24/2024. On 05/24/2024, the facility submitted a removal plan indicating the immediate action that the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan relative to F 600 to remediate the deficient practice including placing Resident #60 on NJ Ex Order 26.4(b)(1) until appropriate placement was found. The facility provided an acceptable removal plan on 05/24/24 at 11:34 PM. The survey team validated that the immediate jeopardy was removed on 05/24/24 at 11:50 PM following the facility's implementation of the plan for removal of the immediate jeopardy.	F 000		

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F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and review of facility policy, the facility failed to ensure adequate supervision of residents by specifically failing to prevent Resident (R) #60 from NJ Ex Order 26.4(b)(1) into NJ Ex Order 26.4(b)(1) leading to NJ Ex Order 26.4(b)(1) with other residents. Due to the vulnerable nature of the nursing home population, a potential for NJ Exec Order 2 or NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 from NJ Ex Order 26.4(b)(1) R #60, or R #60 NJ Ex Order 26.4(b)(1), existed, and the likeliness of R #60 NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) another resident in the facility NJ Exec Order 26.4 and required immediate action to prevent further events of NJ Ex Order 26.4(b)(1) by or to R #60. This deficient practice was identified for one out of two residents (Resident #60) reviewed for NJ Ex Order 26.4(b)(1). The Immediate Jeopardy began on NJ Ex Order 26.4(b) the	F 600	1. Identification of Residents Affected or Likely to be Affected: The DON, Social Services Director, and designee(s) interviewed/assessed residents #R60 with BIMS scores of NJ and above for potential NJ Ex Order 26 Concerns were/were not identified and Resident #R60 placed on NJ Ex O until appropriate alternative placement is found as of NJ Exec Order 26.4b1 The following actions were taken to prevent Resident #R60 from NJ Exec Order 26.4b1 additional NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 Nursing Supervisors and Social Services Director and designee updated resident NJ Ex Order 26.4b1 sheet to describe specific NJ Ex Order 26.4b1 and staff response. • Resident evaluated by primary care provider NJ Exec Order 26.4b1.	7/2/24

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F 600	Continued From page 3 date of the first incident of NJ Ex Order 26.4(b)(1) by R #60. Review of "Nurse Notes" located in the EMR under the "Progress Notes" tab revealed the following entries related to R #60's NJ Ex Order 26.4(b)(1) in residents rooms: a) NJ Ex Order 26.4(b), "Resident entered another resident's room and the resident stated they NJ Ex Order 26.4(b)(1) R #60. No NJ Ex Order 26. were noted and R #60 was sent to the hospital for an evaluation. Upon return, R #60 NJ Ex Order 26.4(b)(1) other residents' rooms;" b) NJ Ex Order 26.4(b), "Resident NJ Ex Order 26.4(b)(1) [R #24's] NJ Ex Orde without anybody knowing it. Then someone was NJ Ex Order 26.4(b)(1) and aides went to the room and found R #60 on [his/her] NJ Ex Order 26.4(b) on the NJ Ex Orc with [his/her] NJ Ex Order 26.4(b)(1) [him/herself]. R #24 admitted that [he/she] was about NJ Ex Order 26.4(b) R #60 as [he/she] is NJ Ex Order 26.4(b)(1) . R #60 continued to NJ Ex Order 26.4 into NJ Ex Order 26.4(b)(1) daily." The facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were informed on 05/24/24 at 6:54 PM that Immediate Jeopardy existed related to the failure to ensure adequate NJ Ex Order 26.4(b)(1) of R #60 to prevent potential NJ Ex Order 2 to other residents by R #60 and prevent NJ Ex Order 2 to R #60 by other residents. An acceptable removal plan was received on 05/24/24 at 11: 34 PM and was verified on-site on 05/24/24 at 11:50 PM. Findings include: Review of the "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" policy last reviewed 05/2023 revealed, " Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to . . . physical abuse . . . the facility will develop and	F 600	• Residents received NJ Exec Orde consultation, medication adjustment, and follow-up. • #R60 provide NJ Ex Order 26.4(b)(1) until alternative placement is found. • Residents will also be with NJ Exe 24/7 during ADL and activities. • IDT reviewed and revised care plans to identify patterns in resident's NJ Ex Order 26.4b1 and implement interventions. Care plan revisions and interventions communicated to front line staff caring for residents. 2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring on 05/24/2024. • Abuse policies were reviewed/updated to include all sources of abuse, including resident to resident. • Abuse investigation procedure and documentation process were reviewed and revised. Administrator and DON educated all staff on changes. • The Social Services Director, DON, and Administrator re-educated all staff on facility abuse policies. • Social Services Director, DON and Administrator re-education all staff on abuse prevention and reporting. • DON and designee educated Nurse Aides and Licensed Nurses on documenting behaviors. Behavior documentation will be monitored by the Social Services Director or designee and care plans will be updated as indicated. Staff will be educated on new interventions either verbally or in written form by the Care Plan Coordinator or	

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F 600	Continued From page 4 implement policies and protocols to prevent and identify abuse or mistreatment of others. Review of the Admission Minimum Data Set (MDS) with an assessment reference date (ARD) of [redacted], revealed R #60 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating NJ Ex Order 26.4(b)(1). Review of the Quarterly MDS with an ARD of [redacted], revealed R #60 had a BIMS score of [redacted] out of 15 indicating [redacted] Review of the "Census" tab located in the electronic medical record (EMR) revealed R #60 was admitted to the facility on [redacted]. Review of R #60's "Med Diag [Medical Diagnoses]" tab located in the EMR revealed R #60 was admitted with [redacted] and [redacted] Review of R #60's Care Plan initiated on [redacted], revealed the first concern/focus area for R #60 was [redacted] into [redacted]. The Care Plan Interventions included: -Educate me/family/caregivers on successful coping and interaction strategies. -If reasonable, discuss my behavior. Explain/reinforce why behavior is [redacted] and/or [redacted] to the resident. -Intervene as necessary to protect the rights and safety of others. Approach/Speak in a [redacted] manner. [redacted]. [redacted] and [redacted] as needed. Minimize potential for my [redacted] by offering [redacted] which [redacted] such as	F 600	designee. • Trauma assessment on all facility residents to assess all residents for any psychosocial impact by 05/31/2024 • In the event of any future resident exhibiting this time of behavior, resident will immediately be placed on 1:1 supervision until primary care, nursing, and psych evaluations can be complete. Outcomes of these evaluations will result in continued 1:1 supervision or the initiation of discharge planning to a facility with a focus on behavior management	

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F 600	Continued From page 5 (activities including playing cards, word games, and arts & crafts). Provide a program of activities that is of interest and accommodates residents' status. -Assess for NJ Ex Order 26.4 -Distract residents from NJ Ex Order 26.4(b)(1) by offering pleasant diversions, structured activities, food, conversation, television, books. Monitor NJ Ex Order 26.4(b Document NJ Ex Order 26.4(b)(1) and attempted diversional interventions in progress notes. Provide structured activities: NJ Ex Order 26.4(b NJ Ex Order 26.4 , NJ Ex Order 26.4(b)(1) strategies including NJ Ex Order NJ Ex Order 26.4(b visits with family. -NJ Ex Order 26.4(b)(1) in place. Review of R #60's "Nurse Note" located in the EMR under the "Progress Note" tab dated NJ Ex Order 26.4(b , [first documentation of R #60 NJ Ex Order 26.4(b)(1)] revealed R # 60 was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The note stated the staff must frequently assist R #60 from NJ Ex Order 26.4(b)(1). The note continued to state the other residents were NJ Ex Order and NJ Ex Order 26.4(b)(1) "While doing rounds on the unit this writer found R #60 in room NJ Ex O in NJ Ex O with NJ Ex Order 26.4(b)(1) . Attempted to NJ Ex Order 26.4(b)(1) and [resident] became very NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) to staff. Resident then proceeded to NJ Ex Order 26.4(b)(1) of NJ Ex Orde , very hard to NJ Ex Order 26.4(Will continue to monitor." Review of R #60's "Nurse Note" located in the EMR under the "Progress Note" tab dated NJ Ex Order 26.4(b revealed, "Resident NJ Ex Order 26.4(b)(1 NJ Ex Order 26.4 when staff tries to NJ Ex Order 26.4(b NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) in NJ Ex Order 26.4(b)(1) and getting NJ Ex Order 26.4(b)(1) , even when NJ Ex Order 26.4(b)(1 to his/her assigned NJ Ex Order resident does not NJ Ex Order 26.4(b)(1) ."	F 600		

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F 600	Continued From page 6	F 600		

Review of the updated "Care Plan" located in the EMR under the "Care Plan" tab revealed a focus area related to R #60 being NJ Ex Order 26.4(b)(1) towards staff and a history of NJ Ex Order 26.4(b)(1) was initiated on NJ Ex Order 26.4(b)(1), with interventions including for R #60 to be evaluated for more appropriate level of care [NJ Ex Order 26.4(b)(1)]. There was a focus related to a NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) initiated on NJ Ex Order 26.4(b)(1) with interventions including NJ Ex Order 26.4(b)(1) as necessary to protect the rights of others.
There was no documented evidence of a history of NJ Ex Order 26.4(b)(1).

Review of R #60's "Nurse Note" located in the EMR under the "Progress Note" tab dated NJ Ex Order 26.4(b), revealed the resident was NJ Ex Order 26.4(b)(1) and going into several NJ Ex Order 26.4(b)(1) on this shift. The note further revealed the resident was evaluated by the physician and recommended to continue NJ Ex Order 26.4((NJ Ex and start a new order for NJ Ex Order 26.4(b)(for NJ Ex Order 26.4(b)(with NJ Ex Order 26.4(b)(1). It was also recommended the resident be transferred to a NJ Ex Order 26.4(b)(1) in the Assisted Living Facility or another Skilled Nursing Facility. All the recommendations were reviewed with the resident's primary physician and his/her family. The resident NJ Ex Order 26.4(b)(1) and there is no documented evidence any attempts were made to transfer the Resident #60 to a facility with a NJ Ex Order 26.4(b)(1).

Review of "Nurse Notes" located in the EMR under the "Progress Notes" tab revealed the following entries related to R #60's NJ Ex Order 26.4(b)(1) in residents rooms:

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F 600	Continued From page 7 - On [redacted], "Resident still [redacted], observed going [redacted], [redacted] by staff, sometimes difficult to [redacted] not [redacted] with other residents." - On [redacted], "Resident was in bed, around 3 AM resident came out of his/her room walking the hallways and going [redacted]. At 4 AM resident [redacted], Resident called the [redacted] to get [him/her] out. Around 11:30 PM resident from [redacted] came out [redacted] to [redacted] and [he/she] has wheelchair coming into [his/her] room, this writer [redacted] back to [redacted]." - On [redacted], "Resident [redacted] requires [redacted], [redacted] on the unit in/out of [redacted], other residents [redacted] redirecting this resident is [redacted] at times and [he/she] can be [redacted] and become [redacted], ongoing [redacted] monitoring, frequent checks as to [his/her] [redacted] - On [redacted], "Patient [R #60] mood is [redacted] but continues to [redacted] and [redacted] - On [redacted], "Received resident in [his/her] room, during this shift resident [redacted] and was going into other resident's room. Patient was [redacted] (sic) [redacted] on several occasion." - On [redacted], "Received pt [R# 60] in [his/her] room . Patient has been [redacted] and [redacted] resident. Resident was	F 600		

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F 600	Continued From page 8	F 600		

NJ Ex Order 26.4(b)(1) several times."

- On NJ Ex Order 26.4(b), "Resident was NJ Ex Order 26.4(b)(1) back to NJ Ex Order 26.4(b)(1) after entering other resident room, Patient has been NJ Ex Order 26.4(b) residents when they asked [him/her] to NJ Ex Order 26.4(b)."

- On NJ Ex Order 26.4(b), "Received resident in [his/her] room, when awake resident was NJ Ex Order 26.4(b)(1). Needs NJ Ex Order 26.4(b)(1). Frequently NJ Ex Order 26.4(b) residents and staff. Another resident, [name redacted] in Room NJ Ex Order 26.4(b)(1) on [R #60]. Stated [R #60] NJ Ex Order 26.4(b)(1) while [he/she] was resting in bed and NJ Ex Order 26.4(b). was unwitnessed. No NJ Ex Order 26.4(b)

The "Care Plan" was updated for R #60 on NJ Ex Order 26.4(b), after the NJ Ex Order 26.4(b)(1) incident to include that the resident would have NJ Ex Order 26.4(b)(1) and be NJ Ex Order 26.4(b)(1) to the nursing station.

Review of additional "Nurse Notes" located in the EMR under the "Progress Notes" tab revealed the following entries related to R #60's NJ Ex Order 26.4(b)(1):

- On NJ Ex Order 26.4(b), "Resident [R #60] went NJ Ex Order 26.4(b) and was asked NJ Ex Order 26.4(b) by the resident. R #60 walked NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)

- On NJ Ex Order 26.4(b), "Resident continues to NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1). Found 2 times NJ Ex Order 26.4(b)(1). continue to NJ Ex Order 26.4(b) back to [his/her] NJ Ex Order 26.4(b)(1)

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F 600	Continued From page 9	F 600		

Further review of Resident #60's Care Plan revealed that after the NJ Ex Order 26.4(b)(, incident between R #60 and R #24, the following interventions were added: " NJ Ex Order 26.4(resident to NJ Ex Order 26.4(b)(1) when [he/she] is noted NJ Ex Order 26.4 toward NJ Ex Order 26.4(b)(1) "

Review of "Nurse Note" dated NJ Ex Order 26.4(b)(revealed, "Resident NJ Ex Or with NJ Ex Order 26.4(b)(using NJ Ex Order 26.4(b)(1) when speaking. Resident continues to NJ Ex Order 26 . Resident NJ Ex Order 26.4(b)(1) when NJ Ex Order 26.4(b)(1) . Resident is NJ Ex Order 26.4(b)(1) at times and NJ Ex Or and NJ Ex Order 26.4(b)(1) when NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) pending. US FOIA (b)(6)] and family made aware. Engage resident in NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(take NJ Ex (outside, offer tasks that NJ Ex Order 26.4(b)(1) ."

On NJ Ex Order 26.4(b) at 2:16 PM, the surveyor observed R #60 NJ Ex Order 26.4(b)(1) of other NJ Ex Order 26.4(b)(1) . Staff were not observed NJ Ex Order 26.4(b)(1) R #60.

On 05/24/24 at 2:15 PM, the surveyor interviewed the Certified Nursing Aid (CNA #3) who stated there wasn't a protocol with R #60. The staff NJ Ex Order 26.4 R #60 out of NJ Ex Order 26.4(b)(1) when he/she was NJ Ex Order 26.4(b)(1) .

On 05/24/24 at 7:15 PM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated she was NJ Ex Or and was not familiar with R #60's NJ Ex Order 26.4(b)(or NJ Ex Order 26.4(b)(1)

An acceptable removal plan was received on 05/24/24 at 11:34 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10 practice including placing Resident #60 on NJ Exec Order 26.4b1 until appropriate placement was found. The survey team verified the removal plan on-site on 05/24/24 at 11:50 PM. NJAC 8:39-4.1(a) NJAC 8:39-9.4(f) NJAC 8:39-13.4	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		7/2/24

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	315136	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 609	Continued From page 11 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to report an NJ Ex Order [redacted] in a timely manner for one (Resident (R) 13) out of one resident reviewed for NJ Exec Order 26.4b1 out 21 sampled residents. The facility further failed to report an NJ Ex Order 26.4(b)(1) between R60 and R24 in out of two residents reviewed for NJ Ex Order [redacted] in a timely manner out of 21 sampled residents. This failure had the potential to place residents at risk of not receiving appropriate care and protection. Findings include: 1. Review of the "Census" tab located in the electronic medical record (EMR) revealed R13 was readmitted to the facility on NJ Ex Order 26.4(b) [redacted]. Review of a quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ Ex Order 26.4(b) [redacted] revealed R13 had a "Brief Interview for Mental Status (BIMS)" score of NJ Ex Orde [redacted] out of 15 indicating the resident was NJ Ex Order 26.4(b)(1) [redacted] Review of R13's nurse "Progress Note" dated NJ Ex Order 26.4(b) [redacted] and located in the EMR under the "Progress Note" tab revealed R13 was found to have NJ Ex Order 26.4(b)(1) [redacted] at 8:30 AM by the U.S. FOIA (b) (6) [redacted]) and let the nurse know. Review of an Administrative "Progress Note" located in the EMR under the "Progress Note" tab	F 609	1. F609 SS=D Reporting Alleged Violations. a. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #13 was reassessed by the Director of Nursing Services on NJ Exec Order 26.4b1 [redacted] to verify the [redacted] NJ Exec Order 26 and extent of NJ Ex Order [redacted] Resident # 60 placed on NJ Exec Orde [redacted] pending appropriate discharge and reassessed by US FOIA (b) [redacted] on NJ Exec Order 26.4b1 [redacted]. The physician and the resident's family member were notified promptly upon completion of the assessment. A thorough investigation was initiated by the Director of Nursing Services and the facility Administrator. b. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected by the same deficient practice. c. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Director of Nursing Services and the Administrator with all direct care staff addressing incidents that require reporting and including appropriate timeframes. d. How the corrective action(s) will be monitored to ensure the practice will not	

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F 609	Continued From page 12 dated NJ Ex Order 26.4(b) at 1:25 PM revealed the previous U.S. FOIA (b) (6) was informed by the nurse on duty of the NJ Ex Order 26. on the NJ Ex Orde of R13. The note indicated R13 had pointed to NJ Ex Order 26.4(b) and told the nurse that, "NJ Ex Order 26.4(b)(1)." The NJ Ex Order 2 were called, and an investigation was initiated. Review of the "NJ Ex Order 26.4(b)(1) " report provided by the facility dated NJ Ex Order 26.4(b) revealed the facility NJ Ex Order 26.4b1 at 12:29 PM and NJ Ex Order 26. responded. The report revealed the call was for a NJ Ex Order 26.4(b)(1) and would be reported to the State Agency (SA). Review of the "Reportable Event Record/Report" dated NJ Ex Order 26.4(b) at 12:00 PM provided by the facility revealed the time of event of the NJ Ex Order 26.4(b) was at 5:00 AM on NJ Ex Order 26.4(b)(, however was not reported to the SA until the next day on NJ Ex Order 26.4(b). 2. Review of the admission "MDS" with an ARD of NJ Ex Order 26.4(b) located in the EMR revealed R60 had a "BIMS) score of NJ Ex Orde out of 15 indicating NJ Ex Order 26 . Review of the quarterly "MDS" with an ARD of NJ Ex Order 26.4(b) revealed R60 had a BIMS score of NJ Ex C out of 15 indicating NJ Ex Order 26.4(b)(1). Review of R24's quarterly "MDS" with and ARD of NJ Ex Order 26.4(b) revealed a BIMS score of NJ Ex out of 15 indicating the resident was NJ Ex Order 26.4(b)(1). The resident had NJ Ex Order 26.4b1. Review of "Progress Note" dated NJ Ex Order 26.4(b) revealed, "[R60] NJ Exec Order 26.4b1 to [R24's] room without anybody knowing it. Then someone was	F 609	recur: The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks and monthly for 2 months. These residents will be assessed and interviewed to ensure that any injuries are identified and are properly investigated and reported to the appropriate team members or the Department of Health. Findings of this audit will be discussed, and this plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met.	

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F 609	Continued From page 13 NJ Exec Order 26.4b1 and aides went to the room and found [R60] NJ Ex Order 26.4(b)(1) with NJ Ex O [redacted]. [R24] admitted that NJ Exec was about NJ Ex Order 26.4(b) [R60] as NJ Exec is not allowed NJ Ex Order 26.4(b)(1)." This incident was not reported to the SA and R60 continued to NJ Ex Order 26.4 [redacted] daily. During an interview on 05/24/24 at 7:15 PM the U.S. FOIA (b) (6) stated the facility had questioned the resident [R24] involved with R60 during the NJ Ex Order 26.4(b) incident, however, the facility did not report the incident to the U.S. FO Review of the "Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating" policy last reviewed 05/2023 revealed, "all reports of resident abuse including injuries of unknown origin, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies as required by current regulations. Findings of all investigations are documented and reported."	F 609		
F 610 SS=D	NJAC 8:39-9.4(f) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 610		7/2/24

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F 610	Continued From page 14 investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to thoroughly investigate a NJ Ex Order 26.4(b)(1) incident between two (Residents (R) 60 and R24) out of two residents reviewed for [redacted] out of a sample size of 21. This failure has the potential for further NJ Ex Order 26.4(b)(1) occurring and not being investigated so interventions can be put in place. Findings include: Review of the admission "Minimum Data Set (MDS)" with an assessment reference date (ARD) of [redacted] and located in the electronic medical record (EMR) revealed R60 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 indicating NJ Ex Order 26.4(b)(1). Review of the quarterly "MDS" with an ARD of [redacted] revealed R60 had a BIMS score of [redacted] out of 15 indicating NJ Ex Order 26.4(b)(1). Review of R24's quarterly "MDS" with an ARD of [redacted] revealed a BIMS score of [redacted] out of 15 indicating the resident was NJ Ex Order 26.4(b)(1). The resident had [redacted].	F 610	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #60 was reassessed by the Director of Nursing Services on [redacted] Resident physician and the resident's family member were notified promptly upon completion of the assessment. A thorough investigation was initiated by the Director of Nursing Services and the facility Administrator. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Director of Nursing Services and the Administrator with all direct care staff addressing situations that require reporting for timely investigations, and their responsibilities related to investigations. 4. How the corrective action(s) will be	

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F 610	Continued From page 15 Review of the "Progress Note" located in the EMR under the "Progress Note" tab dated [redacted] revealed, "[R60] [redacted] without anybody knowing it. Then someone was[redacted] and aides went to the room and found [R60] on [redacted] with [redacted]. [R24] admitted that [redacted] [R60] as [redacted] is not [redacted]." The incident was not investigated and R60 continued to [redacted] daily. During an interview on 05/24/24 at 7:15 PM the [redacted]) stated the facility had questioned the resident [R24] involved with R60 during the [redacted] incident, however, confirmed the facility did not complete a thorough investigation. Review of the "Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating" policy last reviewed 05/2023 revealed, "all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported." NJAC 8:39-9.4(f)	F 610	monitored to ensure the practice will not recur: The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks and monthly for 2 months. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated, and reported to the appropriate people and/or Department of Health. Findings of this audit will be discussed with the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		7/2/24

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F 623	Continued From page 16	F 623		

representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

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must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

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F 623	Continued From page 18 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's transfer form, the facility failed to notify the Ombudsman program of the transfer of two of five residents (Resident (R) 17 and R38) reviewed for hospitalization out of a sample of 21 residents. This failure has the potential for residents to not be aware of their transfer rights. Findings include: 1. Review of the "Progress Notes" in the electronic medical record (EMR) revealed, on NJ Ex Order 26.4(b) R17 was taken to the emergency room (ER) for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) R17 returned to the facility on NJ Ex Order 26.4(b). Review of R17's EMR and hard chart located on the NJ Ex Orde floor held no documentation related to a transfer notice having been issued to the resident. 2. Review of the "Progress Notes" in the EMR revealed R38 had a doctor's appointment on NJ Ex Order 26.4(b) with NJ Ex primary care provider; during this appointment the physician's office sent the resident to the ER due to NJ Ex Order 26.4(b)(1)	F 623	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #17/ #38 and the resident□s representative(s) were immediately notified in writing and in a language and manner they understand upon acute transfer. 2. Identification of other residents having the potential to be affected was accomplished by: All residents who are transfer/discharge have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: (a)All resident and resident□s representative will be notified in writing of the reason for an emergency transfer and date of transfer or discharge to hospital or other related institution and mailed out to address obtain from resident record. (b) U.S. FOIA (b) (6) was in serviced regarding Notice and Transfer or discharge and the resident	

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F 623	Continued From page 19 with [NJ Ex Order 26.4(b)(1)] R38 was readmitted to the facility on [NJ Ex Order 26.4(b)] with a diagnosis of [NJ Ex Order 26.4(b)(1)] [redacted] Review of R38's "Progress Notes" tab in the EMR revealed no documentation of notification into the responsible party or the attending physician. Review of the "Miscellaneous" tab in the EMR revealed no documentation related to related to transfer rights. During an interview on 05/24/24 at 8:28 AM, Licensed Practical Nurse (LPN) 2 stated during a normal transfer to the hospital the nurse assigned to the resident would complete the "Transfer/Bed Hold notice prior to Hospitalization or Therapeutic Leave" form and provide to the resident, or their responsible party if present, or by phone prior to sending the resident out. LPN2 stated a copy would be maintained in the hard chart on the unit and the business office manager would receive a copy of the form. During an interview on 05/24/24 at 2:13 PM, the [U.S. FOIA (b) (6) redacted]) stated she was responsible for gathering the information from bed hold/transfer notices and entered them into a spreadsheet and sent a copy of the spreadsheet to the Ombudsman related to the acute care transfers. The [U.S. FOIA (] was unable to locate copies of the notice of transfer for R17 and R38. Review of the form titled "Transfer/Bed Hold notice prior to Hospitalization or Therapeutic Leave" dated [NJ Ex Order 26.4(b)] revealed the form was to be completed and given to the resident or responsible party at the time of the transfer. The form had spaces for the resident's name, resident responsible party, date of transfer, date notice	F 623	representative must be notified for the reason for the move in writing and in the language and manner they understand. The facility must send a copy of the notice to the representative of the Office of the State Long-Term Care Ombudsman at least 30 days before the resident is transferred or discharged. (c) The Director of Social Services or designee will review the audits all acute transfer weekly for 4 weeks and monthly for 2 months to ensure that all written notifications of the reason for an emergency transfer are sent out certified and received by resident and resident□s representative (sponsor) 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The results of these audits will be discussed in the morning meeting for immediate resolution and will be submitted to the Quarterly Assurance Performance Improvement Committee (QAPI) for review. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months.	

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F 623	Continued From page 20 was being issued, and the location to which the resident was being transferred. R17 and R38 did not have a copy of this form in their EMR or hard chart. Review of the facility policy titled, "Transfer or Discharge, Emergency" last revised 12/01/19 revealed ". . . Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: . . . prepare a transfer form to send with the resident, notify the representative (sponsor) or other family member . . ." NJAC 8:39-5.1(a) NJAC 8:39-5.3(b)	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		7/2/24

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COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

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F 625	Continued From page 21 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide copies of the facility's bed hold policy to four of five residents (Resident (R) 343, R17, R38 and R27) reviewed for hospitalization out of a sample of 21 residents. This failure created the potential for residents and/or responsible parties to not have the information needed to safeguard their return to the facility. Findings include: 1. Review of R343's electronic medical record (EMR), under the "Census" tab revealed an admission date of NJ Ex Order 26.4(b), a discharge to the hospital date of NJ Ex Order 26.4(b), and readmission to the facility on NJ Ex Order 26.4(b). The clinical record lacked evidence that the resident and/or responsible party was given a copy of the facility's bed hold policy when the resident was transferred to the hospital. During an interview on 05/24/24 at 10:14 AM, the U.S. FOIA (b) (6) confirmed the facility failed to provide a copy of the bed hold policy to residents and/or the responsible party upon transfer to the	F 625	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #, #343, R17, R38 and R27 record was reviewed for notification of Bed Hold. The resident and/or legal representative was immediately notified of the facility's bed hold policy. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All resident records were reviewed for notification of bed hold policy. An in-service education program was conducted by the Director of Nursing/Administrator and/or designee with all licensed/non nursing staff addressing the facilities' notification of bed hold policy. 4. How the corrective action(s) will be monitored to ensure the practice will not	

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F 625	Continued From page 22 hospital. 2. Review of the "Progress Notes" in the electronic medical record (EMR) revealed, on [NJ Ex Order 26.4(b)], R17 was taken to the emergency room (ER) for NJ Ex Order 26.4(b)(1) and [NJ Ex Order 26.4(b)(1)] R17 returned to the facility on [NJ Ex Order 26.4(b)]. Review of R17's EMR or hard chart located on the [NJ Ex Ord] floor held no documentation bed hold information had been issued to the resident. During an interview on 05/24/24 at 8:28 AM, Licensed Practical Nurse (LPN) 2 stated during a normal transfer to the hospital the nurse assigned to the resident would complete the bed hold/transfer notice and provide to the resident or their responsible party if present or by phone prior to sending the resident out. LPN2 stated a copy would be maintained in the hard chart on the unit and the business office manager would receive a copy of the form. During an interview on 05/24/24 at 2:13 PM, the U.S. FOIA (b) (6)) stated she was responsible for gathering the information from bed hold/transfer notices and entered them into a spreadsheet and sent a copy to the Ombudsman related to the acute care transfers. The [U.S. FOIA] was unable to locate copies of the bed hold notices for R17. 3. Review of the "Progress Notes" in the EMR revealed R38 had a doctor's appointment on [U.S. FOIA (b) (6)] with [NJ Ex] primary care provider; during this appointment the physician's office sent the resident to the ER due to NJ Ex Order 26.4(b)(1) with [NJ Ex Order 26.4(b)(1)] R38 was readmitted to the facility on [NJ Ex Order 26.4(b)] with a diagnosis of [NJ Ex Order 26.4(b)(1)]	F 625	recur: The Director of Nursing Services/Administrator, or designee, will conduct a random audit of five (5) residents that have been admitted or discharged weekly for four (4) consecutive weeks and monthly for 2 months. These residents' charts will be audited to ensure proper notification of bed hold was provided to the resident and/or legal representative and documented as such. This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met	

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F 625	Continued From page 23	F 625		

NJ Ex Order 26.4(b)(1)

Review of R38's "Miscellaneous" tab in the EMR revealed no documentation bed hold information had been issued to the resident.

During an interview on 05/24/24 at 2:13 PM, the U.S. FOIA (stated was unable to locate copies of the bed hold notices for R38.

4. Review of the "Census" tab located in the EMR revealed R27 was admitted to the facility on NJ Ex Order 26.4(b) .

Review of "Progress Notes" located in the EMR revealed R27 was transferred to the hospital due to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(on NJ Ex Order 26.4(b) and readmitted to the facility on NJ Ex Order 26.4(b) . Further review revealed R27 was transferred to the hospital due to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b) and readmitted to the facility on NJ Ex Order 26.4(b)(1)

Review of the EMR revealed no documentation bed hold information had been issued to the resident.

During an interview on 05/24/24 at 12:15 PM, the U.S. FOIA (b) (6) supplied a transfer notice and Ombudsman notice for R27's hospital transfers. The U.S. FOIA (b) (6) stated R27 did not receive a bed hold notice for the two hospital transfers.

Review of the form titled "Transfer/Bed Hold notice prior to hospitalization or therapeutic leave" dated NJ Ex Order 26.4(b) revealed the form was to be completed and given to the resident or responsible party at the time of the transfer. The form had spaces for the resident's name, resident

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F 625	Continued From page 24 responsible party, date of transfer, date notice was being issued, and the location to which the resident was being transferred. Review of the facility policy titled, "Bed-Holds and Returns" last revised 10/2019 stated, ". . . Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: . . . rights and limitations of the resident regarding bed-holds; the reserve bed payment policy as indicated by the state plan (Medicaid residents); . . .the details of the transfer (per the Notice of Transfer) . . ." NJAC 8:39-5.1(a) NJAC 8:39-5.3(b)	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the "Resident Assessment Instrument (RAI) Manual," the facility failed to ensure "Minimum Data Set (MDS)" assessments accurately reflected residents' status for one of three residents reviewed for NJ Ex Order 26.4(b)(1) from 21 sampled residents (Resident (R) 29). R29's "MDS" did not reflect R29's NJ Ex Order 26.4(b)(1). This had the potential for R29 to have NJ Exec Orde care needs. Findings include: Review of R29's "Admission Record" located in	F 641	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #29 was reassessed on NJ Exec Order 26.4 to include NJ Ex Order 26.4(b)(1) in Minimum Data Set assessments and accurately reflect residents' status. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place	7/2/24

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F 641	Continued From page 25 the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on NJ Ex Order 26.4(b) with diagnoses that included NJ Ex Order 26.4(b) with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) Review of R29's "Admission NJ Ex Order 26.4(b)(1) Assessment," dated NJ Ex Order 26.4(b) and located in the EMR under the "Assessment" tab, revealed R29 had a history of NJ Ex Order 26.4(b)(1) in the NJ Exec O Review of R29's "Physician's Orders" for the month of NJ Ex Order 26.4(b)(1) located in the resident's EMR under the "Orders" tab, revealed an order dated NJ Ex Order 26.4(b) for a NJ Ex Order 26.4(b)(1) due to poor NJ Ex Order 26.4(b)(1) every shift check placement and functionality. Review of R29's admission "MDS" with an Assessment Reference Date (ARD) of NJ Ex Order 26.4(b), located in the resident's EMR under the "MDS" tab, revealed the resident's wandering behaviors and the physician's order for a NJ Ex Order 26.4(b)(1) were not reflected. During an observation on 05/22/24 at 3:05 PM, R29 was in bed with eyes closed and a NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26.4(b)(1). During an interview on 05/24/24 at 9:05 AM, the U.S. FOIA (b) (6)) revealed R29 had a history of exhibiting NJ Ex Order 26.4(b)(1) and had physician orders to wear a NJ Ex Order 26.4(b)(1). U.S. FOIA (b) (6) stated the NJ Ex Order 26.4(b)(1), and the NJ Ex Order 26.4b1 should be documented on the "MDS." During an interview on 05/24/24 at 1:30 PM, the	F 641	to reduce the risk of future occurrence include: An in-service education program was conducted by the Nurse Consultant and the Director of Nursing with all licensed staff including MDS Coordinator(s) addressing the importance of accurately documenting behaviors and orders' to be reflected on admissions and Minimum Data Set (MDS) validating for accuracy during assessment. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents per week to see accuracy of assessments for four (4) consecutive weeks and monthly for 2 months. These residents and their medical records will be assessed to see that all assessments are properly documented and accurate in the medical record. Findings of this audit will be discussed with the Nurse Consultant. This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met.	

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F 641	Continued From page 26 U.S. FOIA (b) (6)) revealed that since R29's NJ Ex Order 26.4(b)(1) were identified in the admission NJ Ex Order 26.4(b)(1) assessment it should have been reflected on the admission "MDS" and it was not. Review of the "RAI Manual," revised October 2023, indicated information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the Interdisciplinary Team completing the assessment. NJAC 8:39-33.2	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		7/2/24

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F 655	Continued From page 27 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on document review, interview, and observation, the facility failed to discuss and present a copy of the baseline care plan for one of 21 sampled residents (Resident (R) 84) within 48 hours of admission; and for one of 21 sampled residents (R29) the facility failed to address the resident's use of a NJ Ex Order 26.4(b)(1). This failure had the potential for care to be provided that may not be consistent with the resident's goals for care. Finding include: 1. Review of the electronic medical record (EMR) under the "Census" tab for R84 revealed an	F 655	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #84 was given a summary of their baseline care plan. A copy of the summary, signed by the resident, resident's representative if applicable, and a facility representative was placed in the medical record. Resident #29 baseline care plan was updated to reflect and address the resident's use of NJ Ex Order 26.4(b)(1) behaviors. 2. Identification of other residents having the potential to be affected was	

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F 655	Continued From page 28 admission date of NJ Ex Order 26.4(b)(with the diagnosis of NJ Ex Order 26.4(b)(1) Review of the "Minimum Data Set (MDS)" with an Assessment Reference Date of NJ Ex Order 26.4(b) revealed a "Brief Interview for Mental Status (BIMS)" score of NJ Ex out of 15, which indicated NJ Ex Order 26.4(b)(1). Review of the EMR "Care Plan" tab revealed a baseline care plan was created on NJ Ex Order 26.4(b)(During an interview on 05/21/24 at 11:42 AM, R84 and his family member denied knowledge of a baseline care plan to include activities of daily living, NJ Ex Order 26.4(frequency of NJ Ex Order 26.4(b)(and goals of care. During an interview on 05/23/24 at 3:00 PM, US FOIA (b)(6), who coordinates assessments and care plans confirmed the nurse that documented the creation of the baseline care plan failed to discuss or present the resident and/or responsible party of the care plan document. 2. Review of R29's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on NJ Ex Order 26.4(b) with diagnoses that included NJ Ex Order 26.4(b)(with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). Review of R29's "Admission NJ Ex Order 26.4(b)(1) Assessment," dated NJ Ex Order 26.4(b) and located in the resident's EMR under the "Assessment" tab, revealed the resident had a history of NJ Ex Order 26.4(b)(1) in the past month.	F 655	accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All interdisciplinary care plan team members responsible for writing baseline care plans will be re-educated on the facility's policy and procedure for developing Baseline Care Plans, which includes procedures for providing the resident a written summary of their baseline care plan and updating MDS. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services (DNS), or designee, will complete random weekly audits of baseline care plans for four (4) consecutive weeks and 2 months,monthly. Random audits will be completed to ensure that baseline care plan summaries are being provided to residents, and that a copy has been placed in the medical record. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Administrator and reviewed in Quality Assurance Committee for comment and suggestions.	

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Review of R29's "Physician's Orders" dated NJ Ex Order 26.4(b) located in the resident's EMR under the "Orders" tab revealed order for NJ Ex Order 26.4 [redacted] due to NJ Ex Order 26.4(b)(1) every shift check placement and functionality.

Review of 29's admission "MDS" with an ARD of NJ Ex Order 26.4(b) located in the EMR under the "MDS" tab revealed the resident's NJ Ex Order 26.4(b)(1) were not reflected.

Review of R29's baseline "Care Plan" developed on 05/03/24 located in the resident's EMR tab "Care Plan" revealed the care plan identified the resident as an NJ Ex Order 26.4(b)(1) however the interventions did not include the physicians' order for the resident to NJ Ex Orde a NJ Ex Order 26.4(b)(1).

During an observation on 05/22/24 at 3:05 PM, R29 was in bed with eyes closed and a NJ Ex Order 26.4b1 [redacted].

During an interview on 05/24/24 at 1:30 PM, the U.S. FOIA (b) (6)) revealed the floor nurse developed the baseline care plan and the Interdisciplinary Team (IDT) developed the comprehensive care plan. The U.S. FOIA confirmed R29's care plan was not developed to reflect the use of NJ Ex Order 26.4(b)(1).

Review of the facility's policy titled "Care Plans," without a review date, directed staff to create a baseline care plan and discuss or present a copy of the care plan to the resident and/or responsible party within 48 hours of the resident's admission.

NJAC 8:39-11.1, 11.2
NJAC 8:39-12.1

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F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced	F 676		7/2/24

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F 676	Continued From page 31 by: Based on record review, interview, and review of facility policy, the facility failed to ensure that seven of eight supplemental residents (R19, R51, R40, R7, R16, R49, and R58) receive adequate assistance obtaining NJ Ex Order 26.4(b)(1). During the group meeting the residents voiced concerns about not getting scheduled showers. This failure has the potential for the residents to experience a decline in their ability to perform their ADLs. Findings include: Review of the facility policy titled "Activities of Daily Living, Supporting" updated October 2021 documented as follows "Residents will be provided with care, treatment and services as appropriate lo maintain or improve their ability to carry out activities of daily living (ADLs) ..." During a group meeting held on 05/23/24 at 2:30 PM, seven (R19, R51, R40, R7, R16, R49, and R58) of the eight residents attending the meeting voiced concerns about not receiving NJ Ex Order 26.4(b according to their wishes. The following comments were made during the group meeting. R19 stated he was told that a staff member must be present to assist with NJ Ex Order 26.4(b and there was not enough staff available to assist the resident with NJ Ex Order 26.4(b) R19 stated it had been NJ Ex Order 26. since he NJ Ex Order 26.4(b)(1) R51 stated all needed was for the staff setup the NJ Ex Order 26.4(b)(1) and NJ Ex O could take the NJ Ex Order 26.4(b)(1). R51 stated NJ Ex O was told there were not enough staff to help with NJ Ex Order 26.4(b)(1) R51 confirmed it had been NJ Ex Order 26.4(b)(1) since NJ Ex Order 26.4(b)(1).	F 676	1. Immediate action(s) taken for the resident(s) found to have been affected include: Residents' #R19, R51, R40, R7, R16, R49 and R58 were all reassessed and have been scheduled for showers, care and service to ensure that all residents' abilities in activities of daily living do not diminish and will be documented in aide POC. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All nursing aides were in-service regarding the facility policy for providing the necessary care and services to ensure that a resident's abilities in activities of daily living with regards to Hygiene-bathing, dressing and oral care. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/Unit Managers/Designee will complete random weekly audits for (10) residents schedule showers dates for (4) consecutive weeks,and monthly for 2 months for validation and review. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been	

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	315136	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 676	Continued From page 32 R40 stated he had been told the same thing about not enough staff to assist with [redacted] R7, R16, R49, and R58 agreed with what R19, R51, and R40 stated. The following residents agreed it had been [redacted] since they were offered [redacted] according to their preference: R7, R16, R19, R40, R49, R51, and R58. 1. Review of R7 annual "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of [redacted], located in R7's electronic medical records (EMR) "MDS" tab, revealed R7 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out 15 points which indicated the resident's [redacted] was [redacted] The resident required NJ Ex Order 26.4(b)(1) with [redacted] Review of R7's "Care Plan" with a revision date of [redacted], located in R7's EMR "Care Plans" tab, revealed R7 was scheduled for [redacted] on the Tuesday and Fridays on the 3-11 shift with the assistance of one staff person. Review of R7s "Bath/Shower Sheets" for the month of [redacted] provided by the facility revealed the resident had only received one [redacted] since [redacted] 2. Review of R16's Medicare "MDS" with an ARD of [redacted], located in R16's EMR "MDS" tab revealed R16 had a "BIMS" score of [redacted] out of 15 points which indicated R16's [redacted] was [redacted] R16 was assessed to require [redacted] with [redacted] and [redacted]	F 676	achieved as determined by the committee.	

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F 676	Continued From page 33 Review of R16's "Care Plans" with a revision date of [redacted], located in the resident's EMR "Care Plans" tab, revealed R16 was scheduled to receive [redacted] on Tuesdays and Fridays on the 3-11 shift with the NJ Ex Order 26.4(b)(1) . Review of R16's '[redacted] Sheets for the month of [redacted] provided by the facility revealed R16 had not received any [redacted] since [redacted]. 3. Review of R19's annual "MDS" with an ARD of 05/07/24, located in the resident's EMR "MDS" tab, revealed R19 had a "BIMS" score of [redacted] out of 15 points which indicated the resident's [redacted] was [redacted] R19 was assessed to require NJ Ex Order 26.4(b)(1) with [redacted] and [redacted] Review R19's "Care Plan" with a revision date of [redacted], located in the resident's EMR "Care Plans" tab, revealed R19 was to receive [redacted] on Wednesday and Saturdays on 7-3 shift with the assistance of one staff member. Review of R19's '[redacted] Sheets" for the month of [redacted] provided by the facility revealed the resident has not received any [redacted] since [redacted]. 4. Review of R40's Medicare "MDS" with an ARD of [redacted], located in R40's EMR "MDS" tab revealed R40 had a BIMS score of [redacted] out of 15 points which indicated R40's [redacted] was NJ Ex Order 26.4(b)(1). R40 was assessed to require NJ Ex Order 26.4(b)(1) with [redacted] The resident was not observed for during the assessment period.	F 676		

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F 676	Continued From page 34	F 676		

Review of R40's "Care Plan" with a revision date of [NJ Ex Order 26.4(b)(1)] located in R40's EMR "Care Plans" tab, revealed R40 was scheduled for [NJ Ex Order 26.4(b)] on Wednesdays and Saturdays on the 3-11 shift with the [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26.4(b)(1)].

Review of R40's "Shower Sheets" for the month of [NJ Ex Order 26.4(b)(1)] provided by the facility revealed the resident had not received any [redacted] since [NJ Ex Order 26.4(b)].

5. Review of R49's annual "MDS" with an ARD of [NJ Ex Order 26.4(b)], located in R49's EMR "MDS" tab revealed R49 had a BIMS score of [NJ Ex] out 15 points which indicated R49's [NJ Exec Order 26.4] was [NJ Ex Order] R49 did not require [NJ Ex Order 26.4(b)(1)] with [NJ Ex Order 26.4(b)]

Review of R49's "Care Plan," with a revision date of [NJ Ex Order 26.4(b)], located in R49's EMR "Care Plans" tab, revealed R49 required the [NJ Ex Order 26.4(b)(1)] [redacted] for [NJ Ex Order 26.4(b)] The care plan did not identify the resident schedule [NJ Ex Order 26.] days.

Review of R49's "Shower Sheets" for the month of [NJ Ex Order 26.4(b)(1)], provided by the facility, revealed R49 had not received any [NJ Ex Order 26.4(b)] since [NJ Ex Order 26.4(b)].

6. Review of R51's quarterly "MDS" with an ARD of [NJ Ex Order 26.4(b)], located in R51's EMR "MDS" tab, revealed R51 had a BIMS score of [NJ Ex] out 15 points which indicated R51's [NJ Exec Order 26.4] was [NJ Ex Order] R51 was assessed to not require [NJ Ex Order 26.4(b)(1)] with [NJ Ex Order 26.4(b)]

Review of R51's "Care Plan" with a revision date of [NJ Ex Order 26.4(b)], located in R51's EMR "Care Plans" tab, revealed R51 required the [NJ Ex Order 26.4(b)(1)] of [NJ Ex O]

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NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b) The care plan did not identify R51's scheduled [redacted] days.

Review of R51's "Shower Sheets" for the month of NJ Ex Order 26.4(b)(1), provided by the facility, revealed R51 had not received any NJ Ex Order 26.4(since NJ Ex Order 26.4(b .

7. Review of R58's annual "MDS" with an ARD of 02/23/24, located in R58's EMR "MDS" tab, revealed R58 had a "BIMS" score of NJ Ex Orde of 15, which indicated R58's NJ Exec Order 26.4(was NJ Ex Order 26.4(b)(1) [redacted] R58 was assessed as not requiring any NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)

Review of R58's "Care Plan" with a revision date of NJ Ex Order 26.4(b , located in R58's EMR "Care Plans" tab, revealed R58 was scheduled for NJ Ex Order 26.4(on Tuesdays and Fridays on the 3-11 shift with assistance of one staff member.

Review of R58's "Shower Sheets" for the month of NJ Ex Order 26.4(b)(1) provided by the facility revealed R58 had only received NJ Ex Order 26.4(b)(1) since NJ Ex Order 26.4(b .

During an interview on 05/23/24 at 3:54 PM, Certified Nurse Aide (CNA) 1 revealed the residents use the NJ Ex Order 26.4(in their rooms. The residents are scheduled for NJ Ex Order 26.4(twice a week on each shift. Those scheduled NJ Ex Order 26.4(are attached to the CNAs assignment sheets. The CNAs are responsible for assisting those residents that require assistance.

An interview with the U.S. FOIA (b) (6)) on 05/24/24 at 1:30 PM revealed the residents are scheduled to take NJ Ex Order 26.4(twice a week in their rooms. The U.S. FOIA reviewed the residents' [redacted] and stated that lacked documentation of

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F 676	Continued From page 36 the residents receiving the scheduled NJ Ex Order 26.4(b) The U.S. FOIA (b) (6) stated it was the facility's expectation residents would receive NJ Ex Order 26.4(b) as they were scheduled. An interview on 05/24/24 at 1:36 PM with the U.S. FOIA (b) (6) revealed the issue of the residents receiving the NJ Ex Order 26.4(b) was discussed with the staff. The U.S. FOIA (b) (6) was asked to interpret the NJ Ex Order 26.4(b) sheets for the month of NJ Ex Order 26.4(b) The U.S. FOIA (b) (6) stated that it was possible that the CNAs did give the NJ Ex Order 26.4(b) but forgot to document the residents received the NJ Ex Order 26.4(b) The U.S. FOIA (b) (6) was reminded that this was a concern voiced by the residents. The U.S. FOIA (b) (6) stated this lack of documentation indicates that a performance improvement plan needs to be developed. NJAC 8:39-27.1(a) NJAC 8:39-27.2	F 676		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of facility policy, the facility failed to ensure that one of two residents (Resident (R)	F 695	1. Immediate action(s) taken for the resident(s) found to have been affected include:	7/2/24

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F 695	Continued From page 37 76) reviewed for NJ Ex Order 26.4(b)(1) from a total sample of 21 residents had NJ Ex Order 26.4(b)(1) changed per physician's orders and had an order for NJ Ex Order 26.4(b)(1). This had the potential for R76 to develop NJ Ex Order 26.4(b)(1). Findings include: Review of R76's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on NJ Ex Order 26.4(b) with diagnoses that include NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(Review of R76's "Physician's Orders," dated NJ Ex Order 26.4(b) and located in the resident's EMR under the "Orders" tab, revealed orders to change and date the NJ Ex Order 26.4(b)(1) every Wednesday on the 11-7 shift. There were no physician's orders for the resident to receive NJ Ex Order 26.4(b)(1) During an observation on 05/22/24 at 10:15 AM, R76 was lying in bed wearing a NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) at NJ Ex Order 26.4(b)(1) . The NJ Ex Order 26.4(b)(1) had a change date of NJ Ex Order 26.4(b). The NJ Ex Order 26.4(b)(1) had a buildup NJ Ex Order 26.4(b)(1) around the NJ Ex Order 26.4(b)(1); the NJ Ex Order 26.4(b)(1) was sticky to the touch. The NJ Ex Order 26.4(b)(1) had a heavy NJ Ex Order 26. of NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(b) set up with NJ Ex Order located at the resident's bedside was dated NJ Ex Order 26.4(b) . During an observation on 05/23/24 at 8:28AM, Licensed Practical Nurse (LPN) 3 confirmed the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) for R76 was still dated NJ Ex Order 26.4(b) . The NJ Ex Order 26.4(b)(1)	F 695	The Director of Nursing/Unit Manager obtained and placed necessary NJ Ex Order 26. equipment and supplies at the bedside of resident # R76 (date) NJ Exec Order 26.4b1 . NJ Ex Order 26.4(b)(1) changed per physician□s orders, dated and NJ Ex Order 26.4(b)(1) clean to prevent buildup of NJ Ex Order 26.4(b)(1) 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with oxygen(respiratory) and tracheostomy care and suctioning have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Director of Nursing/Unit Managers with all direct care staff addressing the significance of providing a clean, dated, tubing for nebulizer treatment and cleaning of concentrators to prevent buildup of dust debris. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing and the nursing management team will review each resident with a physician orders for respiratory/tracheostomy care and suctioning to assure necessary supplies for immediate use if needed are dated as per physician orders and followed on admission, readmission, new orders and reviewed weekly. The Director of Nursing (DON), or designee, will complete random weekly	

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F 695	Continued From page 38 [redacted] still had a [redacted]. The [redacted] was sticky to the touch and had [redacted] around the [redacted]. LPN3 revealed the night shift was responsible for changing the [redacted] on the [redacted] and [redacted] weekly. LPN3 stated the night staff were responsible for cleaning the [redacted] and [redacted] During an interview on 05/24/24 at 9:05 AM, the [redacted]) revealed the 11-7 shift nurse was responsible for changing the [redacted] on the [redacted] and [redacted] on a weekly basis. [redacted] was unaware that R76's [redacted] had not been changed since [redacted]. [redacted] was also unaware that R76 was receiving [redacted] without a physician's order. [redacted] further stated that the maintenance staff was responsible for cleaning the [redacted] Review of the facility's policy titled "Oxygen Administration" with a revision date of 2019 revealed in part ". . .Verify that there is a physician's order for oxygen therapy. Review the physicians order or facility policy for oxygen administration . . ." NJAC 8:39-19.4	F 695	chart audits for four (4) consecutive weeks and monthly for 2 months to ensure that oxygen/tracheostomy care and suction machines and supplies are maintained in a clean and operable condition to prevent build up of dust debris and are available for immediate use if necessary. Audits will ensure that care plans remain updated to reflect these interventions. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee and recommendation.	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following	F 700		7/2/24

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F 700	Continued From page 39 elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, documents review, and interview, the facility failed to assess and document an assessment for the use of NJ Ex Order 26.4(b)(1) and care plan the use of [redacted] for one resident (Resident (R) R75) reviewed for [redacted] out of 21 sampled residents. This failure had the potential for residents with [redacted] to be uninformed of the risk of [redacted] and/or [redacted] associated with [redacted] use. Findings include: Review of the electronic medical records (EMR) under the "Census" tab revealed R75 revealed an admission date of [redacted] with diagnosis including [redacted] and [redacted] Review of the admission "Minimum Data Set" assessment with an assessment reference date of [redacted] revealed R75's "Brief Interview for	F 700	1. Identification of Residents Affected or Likely to be Affected: R75 was assessed and documented an assessment for the use of [redacted] and care plan the use. Risk vs benefits were discussed with the resident and informed consent was given. The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. 2. All residents have the potential to be directly affected by the deficient practice, and bed rails were removed. 3. Immediately following the incident, the DON/Administrator directed the Maintenance team to remove bed rails and licensed nursing staff to place all utilized bed rails in the lowest position and apply fall safety intervention(s) where appropriate.	

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F 700	Continued From page 40 Mental Status (BIMS)" score of [redacted] out of 15, indicating [redacted]. Review of the EMR "Physician's Orders" revealed an order dated [redacted] for [redacted] in use as needed for mobility. Review of the EMR "Assessment" tab and "Miscellaneous" tab lacked documentation of an assessment for the use of the [redacted]. Review of the EMR lacked evidence that risk versus benefits were discussed with the resident and informed consent was given. Review of the EMR under the "Care Plan" tab revealed the use at the [redacted] was not included in the care plan dated [redacted]. During an observation on 05/22/24 at 9:43 AM, R75 was resting in bed with [redacted] on [redacted] at the [redacted]. During an observation on 05/22/24 at 1:24 PM, R75 was in bed with u[redacted] on [redacted]. R75 used the [redacted] to [redacted] from [redacted] to [redacted] of the bed. During observation on 05/23/24 at 4:39 PM, R75 was in bed with the [redacted] During an interview on 05/24/24 at 6:51 PM, the [redacted] confirmed there was no assessment of R75 prior to the use of [redacted] and confirmed the facility lacked policies and procedures for the routine maintenance and safety checks for [redacted].	F 700	4. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 07/02/2024). " All facility policies and procedures regarding bed rails were reviewed/revised. " The DON educated all licensed staff, prior to their next scheduled shift, on the proper use of bed rails per facility policy, the process of determining proper use of side rails depending on resident□s mental and physical status, and the increased risk of injury and death when bed rails are used improperly. " The IDT reviewed and assessed all residents with bed rails to determine the appropriateness of continued bed rail placement and risk of entrapment. Physician orders for the use of bed rails were obtained for residents considered appropriate for the use of bed rails. " The IDT reviewed and revised the care plans of residents with bed rails to ensure they had resident specific interventions to reflect the identified need for bed rails. " The IDT provided education to residents and their responsible parties on the use of bed rails. " The DON and Administrator, or designee, will monitor the utilization of bed rails during rounds that will occur: o Weekly for 4 weeks and then. o Monthly for 2 months and then. o Quarterly " A QAPI PIP was implemented as a means to gather and process information	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 41 Review of the undated facility policy titled "Bed Safety" revealed "Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with side rails" and an assessment was to be completed to determine the least restrictive means for the resident. NJAC 8:39-27.1(a)	F 700	from the monitoring rounds. Findings will be reported at the monthly QAA meeting for a minimum of 2 months	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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, review of the U.S. FOIA (b) (6)) job description, and facility policy review, the facility failed to ensure one refrigerator on the second floor in the	F 812	1. Immediate action(s) taken for the resident(s) found to have been affected include: The Food Service Director immediately	7/2/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315136	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

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F 812	Continued From page 42 nourishment room of three refrigerators in the facility observed had all food labeled, dated and was free of dirt and sticky shelves. The facility further failed to ensure a freezer on the third floor nourishment room out of two observed was free of ice buildup. Findings include: During an observation and interview with the U.S. FOIA (b) (6)) on 05/24/24 at 7:18 AM of the refrigerator on the second floor revealed the following food items not labeled, dated, and/or expired: 1. There were three to-go containers of beans with rice, a small box containing two pieces of fried chicken, a sub sandwich, a to-go container of pasta with bread with no label or date, a clear gallon-sized bag with fried chicken and a biscuit, two 10 ounce bottles of separated liquids that appeared to be apple juice and orange juice, a container of steak, peppers, and mashed potatoes, a to-go soup container in a plastic bag, a clear bag containing four slices of pizza, a small clear container of fruit, a bag of grapes, a piece of cake wrapped in wax paper, a black bag containing a 32 ounce coffee creamer, a clear bag of chocolate, an eight ounce cup of liquid, a container of fruit, a container of cookies, a clear bag of salad, and bag of almonds all with no label or date. There was a clear container of 1.5 pounds (lbs.) of cut watermelon with an expiration date of 05/16/24, a one-third full two-liter bottle of cream soda with an expiration date of 05/20/24, a to-go wrap with an expiration date of 05/16/24, and a half of a peanut butter and jelly sandwich with an expiration date of 05/22/24. The refrigerator was observed to have dirty/sticky	F 812	removed all items not labeled, dated, and expired. Third floor freezers were defrosted and clean to prevent ice build-up. The Food Service Director also cleaned refrigerator that was observed to have dirty/sticky shelves. No resident was affected with this deficient practice 2. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All staff have been in-service on the facility's policies and practice guidelines for reviewing undated Receiving & Storage Policy" "Food brought in by family/visitors". Job description for FSD reviewed with Director. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Dietary Manager or designee will complete random validation reports of dietary staff performing procedures to ensure staff performance is in accordance with the facility policy for 5 weeks and weekly audit for 3 months. Validation checklists will be reviewed by the Registered Dietitian, (RD) until such a time consistent substantial compliance has been achieved as determined by the committee. Findings of this audit will be discussed with the Administrator and this plan of correction will be monitored at the monthly	

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F 812	Continued From page 43 shelves. The U.S. FOIA confirmed the above observations and confirmed the food in the refrigerators should be labeled, dated and food with expiration dates should be thrown out. 2. During an observation on 05/24/24 at 7:51 AM of the third-floor nourishment room, one of two freezers had ice build-up throughout the freezer. The U.S. FOIA confirmed the findings and revealed the door to the freezer did not seal properly. Review of the undated "Receiving & Storage Policy" provided by the facility revealed it is the responsibility of the facility to, "ensure that all foods follow the first in first out (FIFO) method and are labeled and dated." Review of the "Foods Brought by Family/Visitors" last reviewed 05/2023 revealed, "containers will be labeled with the resident's name, the item, and the "use by" date." The policy further revealed the nursing staff will discard perishable foods on or before the "use by" date. Review of the undated "Dining Services" U.S. FOIA job description provided by the facility revealed it is the responsibility of the U.S. FOIA to direct and personally engage in food procurement and storage.	F 812	Quality Assurance meeting until such a time consistent substantial compliance has been met.	
F 880 SS=D	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		7/19/24

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F 880	Continued From page 44	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 45 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure personal protective equipment (PPE) was readily available and that staff donned (put on) the appropriate PPE for two of five residents (Resident (R) 9 and R140) on NJ Ex Order 26.4(b)(1)) out of a total sample of 21 residents. This failure had the potential to increase the risk of the spread of infections. Findings include: 1. Review of R9's "Admission Record" located in the resident's electronic medical records (EMR) "Profile" tab revealed R9 was admitted to the facility on NJ Ex Order 26.4(b with diagnoses that included	F 880	1. Immediate action(s) taken for the resident(s) found to have been affected include: Facility immediately restocks all carts needing personal protective equipment. The certified nursing assistant CNA #7 and LPN 3 was immediately in-serviced on facility protocols on NJ Exec Order 26.4b1 and Use of Personal Protective Equipment, as it pertains to preventing the spread of infection, preventing, identifying, and controlling infections. 2. Identification of other residents having the potential to be affected was accomplished by:	

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F 880	Continued From page 46 NJ Ex Order 26.4(b)(1). Review of R9's "Physicians Orders" dated NJ Ex Order 26.4(b) located in the resident EMR tab "Orders" revealed the resident received NJ Ex Order 26.4(b) to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) [redacted] During an observation on 05/21/24 at 11:14 AM, R9's room had signage posted on the door frame that indicated the resident was on NJ Ex Order 26.4(b)(1) [redacted]. The signage directed the staff to perform hand hygiene before and after entering the room. Staff were to wear gloves and gowns when performing direct care. The NJ Ex Order 26.4(cart outside R9's room contained only gloves and blue face masks, but no gowns. Certified Nurse Aide (CNA) 7 performed hand hygiene and donned gloves and entered the resident's room. CNA7 NJ Ex Order 26.4(R9 with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) During an interview on 05/21/24 at 2:30 PM, CNA7 acknowledged R9 was on NJ Ex Order 26.4(b)(1) [redacted] but there were no gowns available on the NJ Ex Order 26.4(cart when she provided cares to R9. CNA7 stated she was unsure who was responsible for stocking the NJ Ex Order 26.4(carts. 2. Review of R140's "Admission Record" located in the resident's EMR tab "Profile" revealed the resident was admitted to the facility on NJ Ex Order 26.4(b). Review of R140's "Physician Orders" dated NJ Ex Order 26.4(b) located in R140's EMR "Orders" tab revealed R140 was placed on NJ Ex Order 26.4(b)(1) [redacted] related to NJ Ex Order 26.4(During an observation on 05/21/24 at 12:45 PM,	F 880	The facility has determined that all residents/staff have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All licensed and non-licensed nursing, housekeeping, and laundry staff will be in-service on the facility's policy for Infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. In-service training includes observation of each staff member 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing (DON), or designee, will complete a random audit of 4 nurses and 4 CNAs. To ensure nurses are performing the procedure in accordance with our facility's Practice Guideline, random monitoring will occur each week for 4 weeks. Findings of this audit will be discussed with the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met. Corrective action completion date: 07/19/2024	

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F 880	Continued From page 47	F 880		

R140 room's had signage on the doorframe indicating R140 was on NJ Ex Order 26.4(b)(1) [redacted] There was no PPE available on the NJ Ex Order 26.4([redacted] cart outside the resident's room. Licensed Practical Nurse (LPN) 3 performed hand hygiene and donned gloves and entered R140's room without a gown to perform NJ Ex Order 26 [redacted] care on R140's NJ Ex Ord [redacted]

During an interview on 05/21/24 at 3:20 PM, LPN3 confirmed R140 was on NJ Ex Order 26.4(b)(1) [redacted] due to the NJ Ex Order 26 [redacted] on NJ Ex Order 26.4(b) [redacted] that required NJ Ex Order 26.4(b)(1). LPN3 stated there were no gowns available on the NJ Ex Order 26.4([redacted] cart. LPN3 stated R140 was in hurry to be discharged and that was why she did not attempt to obtain an NJ Ex Order 26.4([redacted] gown.

During an interview on 05/24/24 at 9:05 AM, U.S. FOI [redacted]) revealed she was responsible for ensuring the [redacted] carts on the unit had adequate PPE supplies. U.S. FOIA (b) (6) [redacted] confirmed she had not restocked the NJ Ex Order 26.4([redacted] carts on 05/21/24.

NJAC 8:39-19.4

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	061326	A. BUILDING: _____ B. WING _____	C 05/30/2024

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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 review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. 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 established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	S560 Mandatory Access to Care 1. All efforts to hire facility Certified Nursing Aide(s) will continue until there is adequate staff to serve all residents. Until the time, facility will utilize staffing agencies to fill any open spots in the schedule. Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listing, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. No resident was	7/2/24

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

Electronically Signed | 06/21/24

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S 560	Continued From page 1 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. 1. For the 3 weeks of Complaint staffing from 04/03/2022 to 04/23/2022, the facility was deficient in CNA staffing for residents on 18 of 21 day shifts and deficient in CNAs to total staff on 1 of 21 evening shifts as follows: -04/03/22 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -04/04/22 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -04/05/22 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -04/06/22 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -04/09/22 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -04/10/22 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -04/11/22 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -04/12/22 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -04/13/22 had 11 CNAs for 101 residents on the	S 560	affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). 3. Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. 4. The results of these reviews will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review.	

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S 560	Continued From page 2	S 560		

day shift, required at least 13 CNAs.
-04/15/22 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs.
-04/16/22 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs.
-04/17/22 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs.
-04/18/22 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs.
-04/18/22 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.
-04/19/22 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs.
-04/20/22 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-04/21/22 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-04/22/22 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-04/23/22 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs.

2. For the 9 weeks of Complaint staffing from 01/29/2023 to 04/01/2023, the facility was deficient in CNA staffing for residents on 37 of 63 day shifts as follows:

-01/30/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-02/04/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-02/05/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-02/07/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-02/10/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-02/11/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-02/12/23 had 10 CNAs for 100 residents on the

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S 560	Continued From page 3	S 560		

day shift, required at least 12 CNAs.
-02/13/23 had 11 CNAs for 102 residents on the day shift, required at least 12 CNAs.
-02/14/23 had 9 CNAs for 101 residents on the day shift, required at least 12 CNAs.
-02/17/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-02/18/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-02/19/23 had 9 CNAs for 94 residents on the day shift, required at least 12 CNAs.
-02/24/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-02/25/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-02/26/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-02/27/23 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-02/28/23 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-03/01/23 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-03/02/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs.
-03/04/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-03/05/23 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-03/06/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-03/10/23 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-03/11/23 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs.
-03/12/23 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs.
-03/13/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs.
-03/18/23 had 9 CNAs for 90 residents on the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061326	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4	S 560		

shift, required at least 11 CNAs.
-03/19/23 had 6 CNAs for 89 residents on the day shift, required at least 11 CNAs.
-03/21/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/22/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/23/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/24/23 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/25/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/26/23 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/27/23 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-03/28/23 had 7 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-04/01/23 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs.

3. For the 6 weeks of Complaint staffing from 06/11/2023 to 07/22/2023, the facility was deficient in CNA staffing for residents on 40 of 42 day shifts, deficient in CNAs to total staff on 1 of 42 evening shifts, and deficient in total staff for residents on 2 of 42 overnight shifts as follows:

-06/11/23 had 7 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-06/12/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.
-06/13/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.
-06/15/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-06/16/23 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs.
-06/17/23 had 8 CNAs for 83 residents on the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061326	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5	S 560		

shift, required at least 10 CNAs.
-06/18/23 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs.
-06/20/23 had 7 CNAs for 83 residents on the day shift, required at least 10 CNAs.
-06/21/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-06/22/23 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-06/23/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-06/24/23 had 7 CNAs for 87 residents on the day shift, required at least 11 CNAs.
-06/25/23 had 6.5 CNAs for 87 residents on the day shift, required at least 11 CNAs.
-06/26/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.
-06/27/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-06/28/23 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-06/29/23 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-06/30/23 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-07/01/23 had 7.5 CNAs for 91 residents on the day shift, required at least 11 CNAs.
-07/02/23 had 7.5 CNAs for 90 residents on the day shift, required at least 11 CNAs.
-07/03/23 had 7 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-07/03/23 had 5 CNAs to 11.5 total staff on the evening shift, required at least 6 CNAs.
-07/04/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs.
-07/05/23 had 8 CNAs for 85 residents on the day shift, required at least 11 CNAs.
-07/06/23 had 8 CNAs for 85 residents on the day shift, required at least 11 CNAs.
-07/07/23 had 10 CNAs for 85 residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061326	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 6	S 560		

day shift, required at least 11 CNAs.
-07/08/23 had 6.5 CNAs for 85 residents on the day shift, required at least 11 CNAs.
-07/09/23 had 6.5 CNAs for 90 residents on the day shift, required at least 11 CNAs.
-07/10/23 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs.
-07/11/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs.
-07/12/23 had 9.5 CNAs for 90 residents on the day shift, required at least 11 CNAs.
-07/13/23 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-07/14/23 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-07/15/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-07/15/23 had 6 total staff for 97 residents on the overnight shift, required at least 7 total staff.
-07/16/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs.
-07/16/23 had 6 total staff for 97 residents on the overnight shift, required at least 7 total staff.
-07/17/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-07/18/23 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs.
-07/19/23 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs.
-07/20/23 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs.
-07/21/23 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs.
-07/22/23 had 7 CNAs for 95 residents on the day shift, required at least 12 CNAs.

4. For the week of Complaint staffing from 07/30/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts and deficient in CNAs to total staff on 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061326	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 7 of 7 evening shifts as follows: -07/30/23 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -07/31/23 had 9 CNAs for 94 residents on the day shift, required at least 12 CNAs. -08/01/23 had 7.5 CNAs for 93 residents on the day shift, required at least 12 CNAs. -08/02/23 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs. -08/03/23 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs. -08/05/23 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs. -08/05/23 had 5.5 CNAs to 11.5 total staff on the evening shift, required at least 6 CNAs. 5. For the 3 weeks of Complaint staffing from 10/08/2023 to 10/28/2023, the facility was deficient in CNA staffing for residents on 21 of 21 day shifts and deficient in CNAs to total staff on 1 of 21 evening shifts as follows: -10/08/23 had 8.5 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/09/23 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/10/23 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. -10/11/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -10/12/23 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. -10/13/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -10/14/23 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. -10/15/23 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. -10/16/23 had 9 CNAs for 86 residents on the day	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061326	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 8	S 560		

shift, required at least 11 CNAs.
-10/17/23 had 7 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-10/18/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-10/19/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-10/20/23 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-10/20/23 had 5.5 CNAs to 11.5 total staff on the evening shift, required at least 6 CNAs.
-10/21/23 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs.
-10/22/23 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs.
-10/23/23 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs.
-10/24/23 had 8 CNAs for 90 residents on the day shift, required at least 11 CNAs.
-10/25/23 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs.
-10/26/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs.
-10/27/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs.
-10/28/23 had 7 CNAs for 90 residents on the day shift, required at least 11 CNAs.

6. For the 2 weeks of staffing prior to survey from 05/05/2024 to 05/18/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

-05/05/24 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-05/06/24 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-05/07/24 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-05/08/24 had 10 CNAs for 106 residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061326	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 9 day shift, required at least 13 CNAs. -05/09/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -05/10/24 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -05/11/24 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -05/12/24 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -05/13/24 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -05/14/24 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -05/15/24 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -05/16/24 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -05/17/24 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -05/18/24 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs.	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
315136 Y1	A. Building B. Wing Y2	7/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

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 F0600	Correction	ID Prefix F0609	Correction	ID Prefix F0610	Correction
Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed
LSC	07/02/2024	LSC	07/02/2024	LSC	07/02/2024
ID Prefix F0623	Correction	ID Prefix F0625	Correction	ID Prefix F0641	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.15(d)(1)(2)	Completed	Reg. # 483.20(g)	Completed
LSC	07/02/2024	LSC	07/02/2024	LSC	07/02/2024
ID Prefix F0655	Correction	ID Prefix F0676	Correction	ID Prefix F0695	Correction
Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.24(a)(1)(b)(1)-(5)(i)-(iii)	Completed	Reg. # 483.25(i)	Completed
LSC	07/02/2024	LSC	07/02/2024	LSC	07/02/2024
ID Prefix F0700	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.25(n)(1)-(4)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	07/02/2024	LSC	07/02/2024	LSC	07/19/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/30/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061326 Y1	A. Building B. Wing Y2	7/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/02/2024	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	
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	
5/30/2024	☐ 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
	315136	A. BUILDING **02** B. WING _____	**05/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	**89 AVENUE AT THE COMMON** **SHREWSBURY, NJ 07702**

(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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) 05/22/24. The facility was found to be in substantial compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 05/22/24 and the facility and 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 Shrewsbury is a three-story building with a partial basement, constructed in 2006. It is composed of Type II (111) construction and has six smoke compartments. The facility is fully sprinklered with a wet system that has an antifreeze loop. The diesel generator powers 100% of the building. The number of occupied beds was 104 out of 140.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K 345		7/19/24

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

Electronically Signed | 06/21/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315136	A. BUILDING **02** B. WING _____	**05/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	**89 AVENUE AT THE COMMON** **SHREWSBURY, NJ 07702**

(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 345	Continued From page 1 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 9.6.1.3. This deficient practice had the potential to affect all 104 residents. Findings include: A review of the facility's "Fire Alarm Inspection and Test Report," dated 01/09/24, revealed the following deficiencies: Booster Panel Batteries need to be replaced. Duct Smoke Detector Remote LED's (light emitting diode) not functioning. Dialer battery above FACP (fire alarm control panel) failed. An observation on 05/22/24 at 2:55 PM of the FACP dialer battery, located above the FACP by the main entrance, revealed the word "FAIL" written on it in permanent marker. During an interview on 05/22/24 at 2:55 PM, the U.S. FOIA (b) (6) confirmed the findings and stated the facility was unable to locate any documented evidence which showed the deficiencies cited on the fire alarm report had been corrected. NJAC 8:39-31.1(c), 31.2(e)	K 345	K 345 SS=F Fire Alarm System-Testing and Maintenance 1. (a)Immediate Corrective Actions; Fire Alarm Inspection and Test Report dated 01/09/2024 Booster Panel Batteries were replaced. Duct Smoke Detector Remote LED was fixed a functioning. FACP dialer battery replaced by vendor with documented with evidence. (b)Fire Alarm Inspection and Test Report, Duct Smoke Detector Remote LED and FACP dialer battery will audit by the Maintenance Department for proper operation and documentation daily/weekly. 2. Identification of Other Residents. Since all residents are at potential risk for this deficient practice the facility will implement the following. (a) Maintenance staff will audit Fire Alarm Inspection and Test Report for compliance and monitor Booster Panel Batteries daily functionality. 3. Systemic Changes. (a) Ensure all Inspections/Reports are reviewed, and items address immediately. (b) Maintenance staff will audit for compliance 4 weeks and quarterly to ensure inspection reports, LED and batteries are checked daily/weekly and in good operating condition. 4. Monitoring of Corrective Actions; Results of audits will be reported to quarterly Quality Assurance meeting for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315136	A. BUILDING **02** B. WING _____	**05/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	**89 AVENUE AT THE COMMON** **SHREWSBURY, NJ 07702**

(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 345	Continued From page 2 NFPA 70, 72	K 345	comment and recommendations Completion Date 07/19/2024 (Documented Evidence uploaded)	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Survey and Certification Memorandum- (S&C) 13-55-LSC, the facility failed to provide complete sprinkler coverage in accordance with NFPA 101 (2012) Life Safety Code, Section 9.7.1 and NFPA 13 (2010) Standard for the Installation of Sprinkler Systems, Section 8.15.7.5. This deficient practice had the potential to affect staff and 45 residents.	K 351	1. This Plan of Correction is submitted to meet requirements established by state and federal law to provide complete sprinkler coverage in accordance with NFPA 101 (2012) Life Safety Code, Section 9.7.1 and NFPA 13 92010) STANDARD for the installation of sprinkler system. The vendor will be install Sprinkler System Coverage for closet inside the Lounge across from Room 333.	7/19/24

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	315136	A. BUILDING **02** B. WING _____	**05/30/2024**

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K 351	Continued From page 3 Findings include: A review of the "S&C-13-55-LSC," revised 12/20/13 revealed " ...Automatic Sprinkler Requirement Q&A for Nursing Homes ...Closets: Are ...closets required to be sprinklered internally? A [answer] 6. Sprinkler are required in all closets in a nursing home regardless of the size of the closets ..." An observation on 05/10/24 at 10:14 AM revealed that sprinkler coverage was not provided at the heating, ventilation, and air conditioning (HVAC) closet inside the Lounge across from Room 333. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and revealed the facility was not aware that sprinkler coverage was not provided in the closet prior to the survey. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	(Sprinkler was located in room and was behind pipe that was not visible by the eye.) 2. No Residents were affected by this practice, as the area is not currently occupied, and room is currently locked. All residents have the potential to be affected by this practice deficient practice. 3. Maintenance and contractor will check to make sure working and in compliance. 4. Maintenance Director/designee will do weekly audits x4 and then monthly x2 to ensure that sprinkler system in area are according to code. This will be communicated to the Administrator. The Maintenance Director will present audits to monthly QAPI meeting x3 months, or until committee determines practice is no longer deficient. Completion Date 07/19/2024 (Photo provided and uploaded)	
K 363 SS=F	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	K 363		7/19/24

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K 363	Continued From page 4 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 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 observations and interviews, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.6.3. This deficient practice had the potential to affect 64 residents. Findings include: An observation on 03/07/24 at 9:27 AM of the Dietary corridor door revealed the door failed to	K 363	1. Dietary corridor door, 303□s corridor door, and 223□s corridor door was immediately fixed, and all doors latch in the door frame with it was closed. 2. Identification of other residents. Since all residents are at potential risk for this deficient practice the facility will implement the following (a) The maintenance staff will inspect all corridor door and resident doors weekly to make ensure that they latch in the door frame when it is closed.	

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K 363	Continued From page 5 latch in the door frame when it was closed. An observation on 05/22/24 at 9:50 AM of room 303's corridor door revealed the door failed to latch in the door frame when it was closed. An observation on 05/22/24 at 10:45 AM of room 223's corridor door revealed the door failed to latch in the door frame when it was closed. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the findings and stated the facility was unaware the doors were not closing and latching prior to the survey. NJAC 8:39-31.1(c), 31.2(e)	K 363	3. Systemic Changes: (a) Maintenance staff will audit/inspect all corridor door and resident rooms to ensure compliance with latching as it is closed. (b) Maintenance staff will audit the corridor-doors for latching weekly for 5 weeks and quarterly to ensure compliance. 4. Results of the audits will be reported to the administrator and brought to quarterly Quality Assurance meetings for review and recommendations. Completion Date: 07/19/2024 (photo of doors and latching into door frame uploaded)	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers	K 372	1. Rooms 101,321, 322, Clean Utility Room adjacent Room 222 unsealed gaps	7/19/24

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K 372	Continued From page 6 were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect all 104 residents who resided at the facility. Findings include: An observation on 05/22/24 at 9:07 AM of the smoke barrier located inside Room 101 revealed a three-inch unsealed gap at the top of the wall above the shower and ceiling. An observation on 05/22/24 at 9:59 AM of the smoke barrier by Room 321 revealed an unsealed three-inch overcut around metal penetrations above the smoke doors and ceiling, and a two-inch unsealed overcut around a duct penetration in the bathroom of Room 322. An observation on 05/22/24 at 10:43 AM of the smoke barrier, located inside the Clean Utility Room's heating, ventilation, and air conditioning (HVAC) closet adjacent to Room 222, revealed a four foot by one foot gap in the wall. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the findings and stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers prior to the survey. NJAC 8:39-31.1(c), 31.2(e)	K 372	and penetrations were immediately fixed ensuring smoke barriers were protected by system to restrict the transfer of smoke. 2. All residents have the potential to be affected by this deficient practice. 3. U.S. FOIA (b) (6) and Maintenance staff were in serviced to check for unsealed gaps and penetration when inspecting facility rooms and smoke barriers. 4. Maintenance Director/Designee will audits for unsealed gaps and penetration when inspecting rooms and smoke barriers for 5 weeks and quarterly to ensure no rooms have unsealed gaps and penetration. All findings will be brought to the administrator and reviewed in Quality Assurance for recommendations. Completion Date 07/19/2024 (Photos provide of sealed gaps)	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 374		7/19/24

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K 374	Continued From page 7 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, the facility failed to maintain smoke doors to resist the passage of smoke in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 8.5. This deficient practice had the potential to affect 35 residents. Findings include: An observation on 05/22/24 at 9:19 AM of the smoke doors separating the Vending Room and the Dining Room on the first floor revealed a door closer was not installed on one of the double doors. When tested, the door was not self-closing or automatic closing from the open position, allowing a passage of smoke. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the findings and revealed the facility was unaware of the gap between the smoke doors prior to the survey.	K 374	1. Smoke Door separating the Vending Room and the Dining Room on the first-floor door closer to be installed 06/21/2024. 2. All residents are at potential risk for the deficient practice. 3. U.S. FOIA (b) (6) /Staff in serviced on maintaining smoke doors to resist the passage of smoke in accordance with NFPA 101 (Life Safety Code) 2012 Edition. (a) Maintenance staff will check all doors throughout the building for compliance to resist the passage of smoke. (b) Maintenance staff will do audits for 4 weeks and quarterly after to ensure compliance. 4. Results of the audits will be reported to the administrator and brought to QA meeting for review and recommendations as needed.	

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K 374	Continued From page 8 NJAC 8:39-31.1(c), 31.2(e)	K 374	Completion Date 07/19/2024 (evidence of installd door dated 06/21/2024 uploaded)	
K 908 SS=F	Gas and Vacuum Piped Systems - Inspection and CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the oxygen medical gas system in accordance with NFPA 99 (2012), Section 5.3. This deficient practice had the potential to affect all 104 residents. Findings include: An observation on 05/22/24 at 9:55 AM of the Alarm Annunciator Panel for the Oxygen Manifold System revealed the following alarms: "Oxygen Low" "Oxygen Line Pressure Low" "Oxygen Reserve Cylinders in Use" An observation on 05/22/24 at 10:58 AM of the Central Oxygen Supply Room revealed seven H Cylinders (type of oxygen cylinder) were still connected to the Oxygen Manifold system with "pigtails." Six (6) H-Cylinders were also stored in the room.	K 908	1. Oxygen Medical Gas System has been turned off and not in use. 2. All residents have the potential to affected by this deficient practice. 3. Maintenance Staff will be in service on requirements for Gas and Vacuum system inspection and testing. Maintenance Director will do weekly for 5 weeks and quarterly after to audit records of oxygen medical gas system and inspect to make sure system is not in use or turned on for 4 weeks and monthly for 3 monthly in make sure in compliance. 4. Results of this audit will be brought to the attention of the administrator and reviewed in QA meeting for recommendations as needed. Completion Date: 07/19/2024 Completion Date: 07/19/2024 (Evidence uploaded in epoc)	7/19/24

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K 908	Continued From page 9 A review of the facility's "Medical Gas System Inspection and Test Report," dated 04/06/23 provided by the facility revealed the following deficiencies of the oxygen manifold system: "Leaks detected at Pigtails and Right Bank Intermediate Regulator. Repair Quote sent to Facility." Documentation that the system had been repaired and modified in accordance with NFPA 99 was requested by the surveyor on 05/22/24 at 9:55 AM, 10:58 AM, and 2:28 PM; however, the requested documents were not provided by the facility prior to the survey exit. During an interview on 05/22/24 at 3:00 PM, the U.S. FOIA (b) (6) confirmed the findings and revealed the facility could not locate documentation that the system was repaired and modified in accordance with NFPA 99. NJAC 8:39-31.2(e) NFPA 99	K 908		
K 918 SS=F	Electrical Systems - Essential Electric Syste 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	K 918		7/19/24

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K 918	Continued From page 10 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 record review and interview, the facility failed to meet the requirements of weekly inspection of the facility's generator in accordance with NFPA 110 Emergency and Standby Systems (2010 Edition), Section 8.3.4. This deficient practice had the potential to affect staff and all 104 residents. Findings include: A review of the facility's untitled generator inspection records provided by the facility revealed weekly inspection of the generator was	K 918	1. All written records of inspections of the facility□s generator will be always documented and kept in the Maintenance Director Inspection book readily available. 2. All residents have the potential to be affected by this deficient practice. 3. Maintenance Director will do weekly for 5 weeks and quarterly after to audit records of inspections of facility□s generator documentation to ensure that weekly, monthly and annually inspection documentation is kept in the Maintenance inspection book and readily available	

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K 918	Continued From page 11 not conducted for the following weeks: Between April 13, 2024 and April 27, 2024. Between February 28, 2024 and March 13, 2024 Between September 21, 2023 and October 2, 2023 Between August 26, 2023 and September 8, 2023 During an interview on 05/22/24 at 3:40 PM, the U.S. FOIA (b) (6) confirmed the finding and revealed the facility was unable to locate the missing documentation of the weekly inspections of the generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	when needed. 4. Results of this audit will be brought to the attention of the administrator and reviewed in QA meeting for recommendations as needed. Completion Date: 07/19/2024 (Provided Evidence in epoc)	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923		7/19/24

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K 923	Continued From page 12 care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure oxygen cylinders were stored in accordance with NFPA 99 Health Care Facilities Code (2012 Edition), Chapter 11. This deficient practice had the potential to affect staff and 33 residents. Findings include: An observation on 05/22/24 at 10:58 AM of the Central Oxygen Supply and Storage Room located by Dietary, revealed six (6) H-Cylinders were not individually secured from tipping and rupture. Forty-four (44) E-Cylinders were also stored in the room. Full and Empty signs were not provided to show separation, and combustibles (wood) were observed stored within five feet of oxygen cylinders.	K 923	K923 SS=F Gas Equipment-Cylinder and Container Storage 1. All 6 H-Cylinder were immediately secured from tipping and rupture. Signs were placed in room to identify Full and Empty oxygen cylinder, also moved to be 5 feet away from sprinkler immediately. 2. All residents have the potential to be affected by this deficient practice. 3. All staffed in serviced on proper storage/securing of oxygen cylinders/Placement of signs to distinguish between Full and Empty and distance of 5 feet away from combustibles and sprinkler when stored. Maintenance staff will audit for 5 weeks and monthly for 4 months to determine compliance. 4. Findings will be brought to Administrator and reviewed in QA meeting	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 13 During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the findings and stated the facility was not aware the cylinders were missing the full and empty signs, that the cylinders were not individually secured, and that the cylinders were located within five feet of combustibles. NJAC 8:39-31.2(e) NFPA 99	K 923	for recommendations as needed. Completion Date: 07/19/2024 (Evidence upload in epoc)	

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
315136 Y1	A. Building 02 - RELOCATION FACILITY B. Wing Y2	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

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 K0345	07/19/2024	LSC K0351	07/19/2024	LSC K0363	07/19/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	07/19/2024	LSC K0374	07/19/2024	LSC K0908	07/19/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	07/19/2024	LSC K0923	07/19/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
5/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO