STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	**3000 HILLTOP ROAD WHITING, NJ 08759**

(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 Survey Dates: 03/06/23 through 03/09/23 Survey Census: 105 Sample Size: 34 Supplemental Residents: 0 A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. The facility was notified of Substandard Quality of Care (SQC) on 03/07/23 at 12:34 PM related to the failure of the facility to offer appropriate pneumococcal vaccines to five of five residents reviewed for pneumococcal vaccines.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		4/10/23

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

Electronically Signed | 03/23/2023

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F 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review, the facility failed to ensure the physician completed documentation on the *Ex Order 26. 4B1* [redacted] (POLST-used as directions to emergency health personnel in the event of *Ex Order 26. 4B1* [redacted]) for one of four residents (Resident (R) 309) reviewed for advance directives in a total sample of 34 residents. This failure created the potential for residents to not have their wishes honored by emergency personnel should they suffer a health emergency. Findings include:	F 578	1.The POLST for resident R309 has been corrected by the physician to include the physician printed name, phone number, time and the physician professional license number. 3/9/23 2.New admissions and current residents who have a POLST have the potential to be affected. All residents who have a POLST were audited to ensure the document is completed and signed by the physician including the physician printed name, phone number, time, and the physician professional license number. 3/23/23	

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F 578	Continued From page 2 Review of R309's profile, provided by the facility, revealed R309 was admitted to the facility on Ex Order 26. 4B1 with diagnoses that included Ex Order 26. 4B1 [redacted]. Review of R309's "POLST," located in R309's medical record provided by the facility, revealed under the "signatures" section for the physician's printed name, phone number, date/time and a professional license number. The section revealed a signature and date, but failed to reveal the physician's printed name, physician's phone number, time, or the physician's professional license number. Under section "A" of the "POLST," Ex.Order 26.4(b)(1) *Ex Order 26. 4B1* [redacted] was handwritten. R308 Ex.Order 26.4(b)(1) in the facility on Ex.Order 26.4(b)(1) During an interview on 03/09/2023 at 11:26 AM, the Director of Social Services (DSS) stated she reviews the "POLST" with the resident and/or their representative, and ensure the document is filled and signed according to the resident's wishes for treatment. The SSD then flags the document in the resident's chart for the physician's signature. The SSD admitted that the "POLST" was a doctor's order and since it was never filled out by the physician, with his license number, phone number and name, it was not a valid order. During an interview with the attending physician (MD1) on 03/09/23 at 2:23 PM, MD1 stated he	F 578	3.The policy titled *Ex Order 26. 4B1* [redacted] Order was reviewed by the Medical Director and Director of Nursing and no revisions were needed. The Social Worker will educate the staff physicians, medical records and licensed staff by the on the process and appropriate way to complete a *Ex Order 26. 4B1* [redacted] (POLST), which include Physicians printed name, phone number, date/time and professional license number. 4.To ascertain the effectiveness of the education an audit was developed. All new admissions will be audited by the Social Worker/designee to ensure the POLST is completed by the physician to include which include Physicians printed name, phone number, date/time and professional license number for 30 days, then 30% of new admissions for 3 months. Any discrepancies will be followed up by re-education of the physician. The results of the audit will be monitored and reported during monthly QAPI.	

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F 578	Continued From page 3 recalled R309. MD1 stated no one told him he needed to fill in every field in the POLST. MD1 verified that the "POLST" was an order that is flagged in the resident's chart for his signature. MD1 stated someone else explains the details to the family, obtains their signature, and flags it for his signature. MD1 stated he also enters an order and documents in the physician's progress notes and enters a code status according to the resident's wishes. MD1 admitted the POLST document is not valid if not filled out with all required information. Review of undated policy provided by the facility titled '*Ex Order 26. 4B1* Order" revealed as follows: "Our facility Ex.Order 26.4(b)(1) *Ex Order 26. 4B1* and related emergency measures to maintain life functions on a resident when there is a *Ex Order 26. 4B1* Order in effect... I. *Ex Order 26. 4B1* orders must be signed by the resident's Attending Physician on the physician's order sheet maintained in the resident's medical record. 2. A *Ex Order 26. 4B1* (POLST) order form must be completed and signed by the Attending Physician and resident (or resident's legal surrogate, as permitted by State law) and placed in the front of the resident's medical record. a. Use only State-approved forms. 3. Should the resident be transferred to the hospital, a photocopy of the POLST order form must be provided to the personnel transporting the resident to the hospital." NJAC 8:39-4.1(a)2	F 578		

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F 578	Continued From page 4 NJAC 8:39-9.6(a) NJAC 8:39-35.2(d)14	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F 580		4/10/23

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F 580	Continued From page 5 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure Licensed Practical Nurse (LPN#3) notified one resident's (Resident (R) 2) legal guardian out of a total sample of 34 residents, immediately of a change in condition, which required Ex.Order 26.4(b)(1) [redacted] Findings include: Review of R2's electronic medical record (EMR) titled "Admission Record," located under the "Profile" tab, indicated the resident was admitted to the facility on Ex Order 26. 4B1 with a diagnosis of *Ex Order 26. 4B1* . Review of R2's EMR quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/26/22 indicated a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 which revealed R2 was *Ex Order 26. 4B1* [redacted]. The assessment indicated R2 required Ex.Order 26.4(b)(1) [redacted] for bed Ex Order 26. 4B1 and	F 580	1.Resident R2's responsible party was notified of the change in condition on 2/21/23 at 9:09 a.m. LPN4 and LPN3 received one on one education on the policy Change in Residents Condition or Status on promptly notifying the resident/resident representative of a change in condition/status. 2.Any resident with a change in condition may potentially be affected by this practice. All residents who have a change in condition in the last 30 days that required a physician ordered treatment will be audited to ensure prompt notification to the resident/resident representative. Any discrepancies will be immediately resolved by notifying the resident/resident representative and re-education of staff. 3.The policy titled Change in Residents	

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F 580	Continued From page 6 transfers. The assessment indicated R2 was assessed for the development of Ex Order 26. 4B1, was Ex.Order 26.4(b)(1) the development of Ex Order 26. 4B1 , and had no Ex Order 26. 4B1. Review of R2's EMR titled nursing "Progress Notes," located under the "Prog (Progress)" tab and dated 02/18/23, indicated LPN3 was notified by a Certified Nursing Assistant (CNA) that R2 had Ex Order 26. 4B1 on the Ex Order 26. 4B1 and Ex Order 26. 4B1. LPN 3 indicated the resident had Ex.Or and obtained an order to apply Ex Order 2 prep on the areas and to Ex.Order 26.4(b)(1) from R2's Ex Order 26.4. Review of R2's EMR titled nursing "Progress Notes," located under the "Prog" tab and dated 02/21/23, indicated a nurse notified the resident's legal guardian three days after the change in condition. During an interview on 03/09/23 at 9:31 AM, LPN 4, who was also the Unit Manager on the Ex.Order 26.4(b)(1) unit, stated she was the one who notified R2's legal guardian on 02/21/23. During an interview on 03/09/23 at 10:00 AM, LPN 3 confirmed she was the nurse who was notified by a CNA of R2's Ex Order 26. 4B1 on his Ex Order 26. 4B1 . LPN 3 stated she typically does notify a resident's representative immediately when there was new treatment ordered for a resident. During an interview on 03/09/23 at 1:00 PM, the Director of Nursing (DON) stated staff were to notify the resident's representative when there was any change in condition.	F 580	Condition or Status was reviewed by the Medical Director and Director of Nursing and no revisions were needed. The Director of Nursing /designee will educate all licensed staff regarding immediate notification to resident/resident representative of change in condition , which required a physician ordered treatment. 4.The Unit Manager/Designee will review the 24-hour reports daily for change in condition to ensure appropriate notification and documentation of physician and responsible party. To ascertain the effectiveness of the education an audit was developed. The Director of Nursing will review the 24-hour report sheets for 30 days, then 3 days per week for 3 months for any changes in condition/status of a resident that required physician intervention to ensure prompt notification to the resident/resident representative. Audit results will be reported during monthly QAPI.	

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F 580	Continued From page 7 Review of a document provided by the facility titled "Change in Resident's Condition or Status," dated 10/19, indicated ". . .Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. . .A 'significant change' of condition is a major decline or improvement in the resident's status that. . .Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. . ."	F 580		
F 641 SS=D	NJAC 8:39-13.1(c) 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 record review and interviews, the facility failed to accurately code the "Minimum Data Set (MDS)" assessment for one of three residents (Resident (R) 108) reviewed for discharge out of a total sample of 34 residents. Findings include: Review of the facility provided "Face Sheet" revealed that R108 was admitted on Ex Order 26. 4B1 with a diagnosis of Ex Order 26. 4B1 [redacted]. Further review revealed that R108 was discharged on Ex Order 26. 4B1. Review of the facility provided, Discharged Return	F 641	1.The MDS record for resident R108 was corrected, transmitted and accepted on 3/7/23 2.All residents being discharged have the potential to be affected. All residents who were discharged in the last month will be audited to ensure accurate coding on the MDS. Any discrepancies will be corrected immediately 3.The Director of Nursing will educate the MDS Coordinator on regarding the accuracy of assessment with discharge coding. 3/10/23	4/10/23

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F 641	Continued From page 8 Not Anticipated "MDS" tracking assessment dated 02/06/23 revealed that R108 had a planned discharge to the [redacted]. Review of the "Clinical Physician Orders," facility provided and dated 02/06/23, revealed that R108 was [redacted]. Review of the "Progress Note," facility provided and dated 02/03/23, revealed that "The social worker made a call to R108's [redacted] to present R108's Notice of Medicare Coverage (NOMNC) with last covered date (LCD) of 02/05/23. She provided education on appeal and R108's [redacted] said that [redacted] would have to speak with R108's [redacted]. Said that [redacted] spoke with [redacted], who said that an appeal was filed. R108 lost the appeal and will be [redacted] on [redacted], which the [redacted] will transport." Review of the "Discharge Instructions," facility provided and dated 02/06/23, revealed that R108 was [redacted]. R108 was referred to [redacted] and was to follow up with [redacted]. Interview with the Director of Social Services on 03/07/23 at 2:13 PM, confirmed that R108 was [redacted] with [redacted]. Interview with the MDS Coordinator on 03/07/23 at 2:48 PM, confirmed that R108 was [redacted] The MDS Coordinator verified that the "MDS" was not coded accurately for discharge.	F 641	4.To ascertain the effectiveness of the education the MDS Coordinator/Designee will conduct 5 random audits weekly x 4 weeks, then 5 monthly x 2 months validating accurate coding for discharge. Audit results will be reported during monthly QAPI	

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F 641	Continued From page 9 NJAC 8:39-33.2(d)	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure one of three residents (Residents (R) 48) reviewed for care planning out of a total of 34 residents was	F 657	1.Resident R48 care conference was completed on 3/20/23 and R48 was in invited and attended. The Social Worker Assistant received one	4/10/23

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F 657	Continued From page 10 invited to participate in their quarterly care plan meetings. Findings include: Review of R48's electronic medical record (EMR) "Admission Record," located under the "Profile" tab, indicated the resident was admitted to the facility on [redacted]. Review of R48's EMR quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 01/07/23 indicated a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 which revealed R48 was [redacted]. During an interview with R48 on 03/06/23 at 10:38 AM, the resident stated [redacted] was not sure [redacted] was invited to [redacted] quarterly care plan meeting. During an interview on 03/07/23 at 4:16 AM, Social Services Assistant (SSA) stated R48 was not invited to [redacted] care conference. SSA stated she normally invites residents and/or the family members on a quarterly basis and just missed inviting R48 to [redacted] care plan meeting. During an interview on 03/09/23 at 1:01 PM, the Director of Nursing (DON) stated the resident and their representative were to be invited to their care conference meetings. Review of a document provided by the facility titled "Care Planning," dated 10/21, indicated ". . . Our facility's Care Planning/Interdisciplinary 'Team is responsible for the development of an individualized comprehensive care plan for each resident. . .The resident, the resident's family	F 657	on one education on the policy titled Care Planning and the requirement to invite the resident/representative to each care conference for that resident. 3/22/23 2.All residents have the potential to be affected. All residents who had scheduled care plan conferences in the last 30 days were audited to ensure the resident/resident representative were invited. Any discrepancies will be corrected by initiating a care conference and inviting the resident/resident representative. 3.The policy titled Care Planning was reviewed by the Administrator and Social Worker and no revisions were needed. The Administrator educated the social work department regarding the residents and responsible parties right to be invited and participate in their care conferences on a quarterly and annual basis. 3/2023 The Social Worker will now send a letter to the resident/resident representative informing them of the upcoming date and time of their care conference. The Social Worker will document in the medical record the date the letter was given and/or sent to the resident/resident representative. 4.To ascertain the effectiveness of the education an audit was developed. The Social work Director/designee will audit 5 medical records weekly for 4 weeks than 5 monthly x 3 months to ensure documentation is present that the resident and/or resident representative was invited	

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F 657	Continued From page 11 and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. . ." The policy failed to address the care conferences were to be held after each assessment (annual, quarterly) of the resident.	F 657	to the care conference. Audit results will be reported out during monthly QAPI.	
F 756 SS=D	NJAC 8:39-4.1(a)3 NJAC 8:39-13.2(a) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 756		4/10/23

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F 756	Continued From page 12 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure the attending physician provided a clinical rationale for declining the pharmacist recommendation for one of five residents (Resident (R)309) reviewed for unnecessary medications out of a total sample of 34 residents. This failure increased the risk that residents will continue to receive unnecessary medications that potentially could cause serious adverse effects. Findings include: Review of R309's profile, provided by the facility, revealed R309 was admitted to the facility on Ex Order 26. 4B1 with diagnoses that included Ex Order 26. 4B1 [redacted]. Review of "Physician Orders," under the "Orders"	F 756	1.The record for resident R 309 was reviewed with the MD, the order for Ex Order 26. 4B1 was discontinued on 3/6/23. 2.All residents who receive drug regime reviews have the potential to be affected. All drug regime reviews in the last 30 days were reviewed to ensure an appropriate physician response with a rationale for the response is present. Any discrepancies will be given to the physician for added response. 3.The policy titled Ex Order 26. 4B1 was reviewed by the pharmacy consultant and the Director of Nursing and no revisions were needed. The pharmacy consult will educate all attending physicians regarding periodic drug medication regimes to identify weather there is a clear indication for treating that individual with the medication, dosage, frequency, duration, and potential side	

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F 756	Continued From page 13 tab in the electronic medical record (EMR), revealed R309's medication regimen included the following medication order, dated 02/24/23: "Ex Order 26. 4B1 -Give Ex tablet by mouth at bedtime for Ex.Order 26.4(b)(1) ." Review of the document labeled "Electronic Pharmacist Information Consultant," located in the "Miscellaneous" tab of the EMR and dated 02/25/23, revealed a note from the consultant pharmacist as follows: "In the geriatric population, Ex Order 26. 4B1 increased risk of Ex Order 26. 4B1 in persons with Ex Order 26. 4B1 . If continuing present therapy. Please document risk vs. benefit." The document revealed the physician's response was "not accepted" with no rationale provided for not accepting the pharmacist's recommendation. The document was signed by the physician and dated 03/01/23. During an interview with the attending physician (MD1) on 03/09/23 at 2:23 PM, MD1 stated whenever he was present in the facility, he signed pending orders flagged for his signature, and did not recall needing to fill in a rationale for a pharmacist recommendation. Review of policy titled "Medication Therapy," updated 1/2023, revealed " . . . 3. Upon or shortly	F 756	effects. The physician will identify where the medication will be tapered, changed or discontinued. Additionally, the physician will identify the risk verses benefit and document their rational in the medical record. 3/17/2023 4.To ascertain the effectiveness of the education an audit was developed. The Director of Nursing/Designee will audit all pharmacy reviews for 30 days, then 30% for 2 months, that have documentation by the physician not accepted to ensure the physician documented a response with a rationale. Any discrepancies will be given to the physician for added response. These will be reviewed at the monthly psychotropic meetings and be reported out in the monthly QAPI.	

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F 756	Continued From page 14 after admission, and periodically thereafter, the staff and practitioner (assisted by the consultant pharmacist) will review an individual's current medication regimen, to identify whether a. there is a clear indication for treating that individual with the medication; b. the dosage is appropriate; c. the frequency of administration and duration of use are appropriate; and d. Potential or suspected Sid effects are present . . . 4. Periodically, and when circumstances are present that represent a greater risk of medication-related complications, the staff and practitioner will review the medication regimen for continued indications, proper dosage and duration, and possible adverse consequences. 5. The physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example : a. when a medication is being given in excessive doses, for excessive periods of time, without adequate monitoring, or in the absence of a valid clinical rationale . . . " NJAC 8:39-23.2(a)(b)	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		4/10/23

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F 758	Continued From page 15 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, review of the Food and Drug Administration (FDA) warning	F 758	1.The record for residents R73 was reviewed with the MD, the order for	

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F 758	Continued From page 16 (www.fda.gov), and policy review, the facility failed to ensure one (Resident (R) 73) of six residents reviewed for unnecessary medications out of a total of 34 residents, had adequate indications for use and Ex.Order 26.4(b)(1) for an *Ex Order 26. 4B1* medication. Findings include: Review of R73's electronic medical record (EMR) "Admission Record," located under the "Profile" tab, indicated the resident was admitted to the facility on *Ex Order 26. 4B1* with *Ex Order 26. 4B1* Review of R73's EMR "Care Plan," located under the "Care Plan" tab and dated 12/01/22, indicated the resident received a *Ex Order 26. 4B1* medication due to *Ex Ord* diagnosis of *Ex Order 26. 4B1*. Review of R73's EMR "Medication Administration Record (MAR)," located under the "Orders" tab and dated 12/01/22 through 03/06/23, indicated R73 received *Ex Order 26. 4B1* *Ex Order* tablet twice a day to treat *Ex Ord* diagnosis of *Ex Order 26. 4B1*. The "MAR" revealed the resident's Ex.Order 26.4(b)(1) not there) were to be monitored. There was no evidence of Ex.Order 26.4(b)(1) Review of R73's EMR nursing "Progress Notes," located under "Prog (Progress) Notes" and dated 12/01/22 through 03/06/23, indicated the resident had no documented Ex.Order 26.4(b)(1) .	F 758	*Ex Order 26. 4B1* was discontinued on 3/15/23 2.All residents who receive *Ex Order 26. 4B1* medications have the potential to be affected. An audit was completed by the Director of Nursing and psych NP consultant on all resident who are receiving *Ex Order 26. 4B1* to ensure adequate indication for use and Ex.Order 26.4(b)(1) are present. Any discrepancies will be reviewed by the physician for a possible medication gradual does reduction (GDR) 3.The policy titled *Ex Order 26. 4B1* was reviewed by the pharmacy consultant and the Director of Nursing and no revisions were needed. The pharmacy consultant will educate the attending physicians and the *Ex Order 26. 4B1* NP regarding periodic drug medication regimes to identify weather there is a clear indication for treating that individual with the medication, dosage, frequency, duration, and potential side effects along with appropriate diagnosis. The physician will identify where the medication will be tapered, changed or discontinued. Additionally, the physician will identify the risk verses benefit and document their rational in the medical record. 3/17/2023 4.To ascertain the effectiveness of the education the Director of Nursing /Designee will audit all *Ex Order 26. 4B1* NP reviews for 30 days, then 30% for 2 months noting the indication for use and possible inappropriate diagnosis. Any discrepancies will be given to the physician for added response . These will	

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F 758	Continued From page 17 Review of R73's EMR physician "Orders," located under the "Orders" tab and dated 12/04/22, revealed the resident received *Ex Order 26. 4B1* tablet twice a day to treat his *Ex Order 26. 4B1*. Review of R73's EMR admission "Minimum Data Set (MDS)" with an Assessment Reference Date of 12/08/23 indicated a "Brief Interview for Mental Status (BIMS)" score of out of 15 which revealed R73 was *Ex Order 26. 4B1*. The assessment indicated R73 had a diagnosis of *Ex Order 26. 4B1*. The assessment indicated the resident was on an *Ex Order 26. 4B1* medication. Review of a document provided by the facility titled, "[name] Elder & Behavioral Health," dated 02/07/23, indicated R73 was evaluated by a Ex.Order 26.4(b)(1) (NP). The NP indicated in his report the resident had no history of *Ex Order 26. 4B1* and had even reached out to the resident's Family Member (FM) 1 to verify this information. NP indicated in the report to taper the *Ex Order 26. 4B1* off and to replaced with an *Ex Order 26. 4B1* for R73's *Ex Order 26. 4B1*. Review of a document provided by the facility titled "Report of Consultation," dated 02/07/23 and signed off by the NP, indicated R73 had no history of *Ex Order 26. 4B1*. A hand-written note, dated 02/08/23 on the lower part of this document, indicated a nurse contacted the resident's primary care physician. The hand-written note revealed the resident had no Ex.Order 26.4(b)(1).	F 758	be reviewed at the weekly x4 at the Ex.Order 26.4(b)(1) meetings then monthly and be reported out in the monthly QAPI.	

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F 758	Continued From page 18	F 758		

Review of R73's EMR nursing "Progress Notes," located under "Prog Notes" and dated 02/08/23, indicated the nurse spoke with the R73's primary care physician about the NP's recommendations and there were Ex.Order 26.4(b)(1) since R73's Ex.Order 26.4(b)(1) .

During an interview on 03/07/23 at 2:59 PM, Registered Nurse (RN) 1, who was also the Unit Manager, stated R73 was not known to Ex.Order 26.4(b)(1) .

During an interview on 03/07/23 at 4:19 PM, the NP confirmed he was the one who completed the Ex Order 26. 4B1 medication review dated 02/07/23 for R73. The NP stated he spoke with the resident's FM1 who confirmed the resident had no Ex Order 26. 4B1 history such as Ex Order 26. 4B1 . The NP stated the resident's primary care physician did not agree with his recommendations. The NP stated R73 shared with him that Ex Ord has difficulty with Ex Order 26. 4B1 .

During an interview on 03/08/23 at 1:58 PM, FM1 stated R73 had no history of Ex Order 26. 4B1 . FM 1 stated the resident had no history of Ex.Order 26.4(b)(1) Ex Order 26. 4B1 or others. FM 1 stated the resident needs an Ex Order 26. 4B1 medication.

During an interview on 03/09/23 at 12:43 PM, R73's primary care physician stated he was the one who requested a medication evaluation from the NP. The physician stated the resident required the use of Ex Order 26. 4B1 for Ex.Order 26.4(b)(1) related to Ex Order 26. 4B1 and was a Ex Order 26. 4B1 .

During an interview on 03/09/23 at 1:02 PM, the

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F 758	Continued From page 19 Director of Nursing (DON) stated the diagnosis of Ex Order 26. 4B1 was to be removed from the clinical record. Review of FDA warning located at www.fda.gov, dated 2009, indicated ". . .WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH Ex Order 26. 4B1 . . Ex Order 26. 4B1 drugs are associated with an increased risk of death. . Ex Order 26. 4B1 is not approved for elderly patients with Ex Order 26. 4B1 Related Ex Order 26. 4B1 . . .Indication. . . Ex Order 26. 4B1 . .Adults. . Ex Order 26. 4B1 . . .Adults. . Ex Order 26. 4B1 . . ." Review of a document provided by the facility titled "Medication Therapy," dated 01/23, indicated ". . .Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. . .Medications use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments. . ."	F 758		
F 812 SS=F	NJAC 8:39-29.2(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.	F 812		4/10/23

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F 812	Continued From page 20 (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 observations, interview, record review, and policy review, the facility failed to ensure that the kitchen was maintained in a sanitary manner for 104 out of 105 residents (one resident was receiving nutrition through tube feeding). Specifically, ice machines in the kitchen and unit pantries were not found to be kept in a sanitary manner, food items were found in dry and cold storage to be passed their "use by" dates, and refrigerators were found to contain unlabeled food items brought in by residents' family and were observed to have grime and food residue on the inside. Findings include: 1. During the initial kitchen tour on 03/06/23 at 9:20 AM with the Food Service Director (FSD) the following observations were recorded: In the second of two designated dry storage areas, a 10 pound, opened plastic bag of whole grain rotini pasta with a use by date of 01/22/23 was observed. The FSD stated it should have gone in the garbage and that he is the person in charge of discarding expired food items.	F 812	1.On 3/8/23 All items in the nutrition rooms, pantry, and refrigerator were checked and either discarded or labeled and dated appropriately. The 10-pound bag of whole wheat pastas were discarded. The 12 pack hamburger buns were discarded. The container of apple sauce was discarded. The 16-ounce container of salad was discarded. On 3/9/23 All Ice machines identified were cleaned and sanitized to remove the unknown substance. 2.All residents keeping food in the nutrition room refrigerator or use the ice machine could be affected. 3.The Food Service Director/designee will check all pantries on each resident unit to ensure that food items brought in for residents are in appropriate containers, labeled and dated. No other food items were found. The Director of Nursing and the Infection Control nurse will educate the maintenance staff on the proper way to clean and sanitize the ice machines,	

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F 812	Continued From page 21 The ice machine was observed with a black, spotty residue on the interior curtain panel. The FSD stated it was cleaned once a month and the cleaning log indicates it was last cleaned on 03/01/23. The FSD indicated that the kitchen was responsible for cleaning the ice machine and that he didn't know if the residue was mold. During a follow up visit to the kitchen on 03/07/23 at 4:17 PM, the ice machine was observed with less black, spotty, residue. The FSD stated that maintenance came, cleaned it and stated that "it wasn't mold." 2. During a follow up visit to the kitchen and an initial tour of the three-unit pantries with the FSD on 03/08/23 at 10:13 AM the following observations were made: In the first of two designated dry storage areas a 12-pack of hamburger buns was observed with a "use by" date of 03/07/23. On the '[Ex Order 2] unit" the ice machine was observed with a white residue on the front, bottom, and sides of unit. The ice and water chutes were encrusted with a hardened substance. The FSD stated he was not sure who oversaw the unit ice machines but that the machines looked like they needed to be wiped down. On the '[Ex Order 26, 4B] unit" the ice machine was observed with a white residue on the bottom tray of the unit. The unit refrigerator contained a 16-ounce potato salad labeled with a first name only and no room number on the food item. Licensed Practical Nurse (LPN) 5 was interviewed immediately, she stated she did not label that food item, but that when food is	F 812	removing all unknown substances. 3/9/23 The Director of Nursing and the Infection Control nurse educated the dietary and nursing staff on the proper dating and labeling of food items that are kept in the pantry and in the unit refrigerators. 4.To ascertain the effectiveness the Maintenance Director/Designee will conduct weekly inspections on all ice machines x 4 weeks than monthly x 3 months. Ice machines will be cleaned weekly and deep cleaned quarterly. Findings will be reported out in monthly QAPI. The Food service director/designee will audit the pantries and unit refrigerators 2 x Daily x 4 weeks, then weekly x 3 months. Findings will be reported out in the monthly QAPI.	

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F 812	Continued From page 22 received on the unit, the staff label and date it. On the '[redacted] unit" the ice machine was observed with a white residue on the bottom tray of the unit. The unit refrigerator contained an 8-ounce Styrofoam bowl of applesauce for med pass with a use by date of 03/07/23. The FSD stated that the applesauce should be thrown out. The refrigerator also contained a 16-ounce salad that had a first name only and no room number on the food item. There was no staff readily available on the unit at that time. The FSD stated he wasn't sure who was in charge of the food items in the refrigerators on the units but that the facility did have a policy on food from outside. During an interview on 03/08/23 at 12:49 PM with the Maintenance Director (MD) it was revealed that his department oversees cleaning the ice machines. He stated that he looked at the machine on the [redacted] unit and that's a "buildup in that tray.," He stated that monthly checks were conducted on the ice machine and deep cleanings were due quarterly. He indicated that "I don't have any idea what it was (referring to the spotty residue on the kitchen ice machine), we had the regional director come in as well, they said that it wasn't mold, but some kind of residue, but not mold, it should be cleaned though, the machine is only six months old." The MD said the ice machines on the units with crust-like buildup had been cleaned and they "cleared the caps." On 03/09/2023 at 12:59 PM during a follow up interview with the FSD he stated that the policy on "Receiving Goods" is the same policy as "Dry Storage" as it covered all food items that the facility received. He stated that items that come in get a label indicating received date, once the	F 812		

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F 812	Continued From page 23 product is opened it gets an opened and used by date. The FSD indicated that he maintains the outside of the ice machine in the kitchen, the inside is "their" (maintenance's) responsibility. The ice machines on the unit are entirely maintenance's responsibility. The kitchen is only responsible for the food that they deliver to the unit for residents. Review of the undated facility's policy titled, "Foods Brought by Family/Visitors," revealed, "Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of resident ... Safe food handling practices are explained to family/visitors in a language and format they understand ...Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food... Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the "use by" date ... " Review of the undated facility's paper policy titled, "Water Management Plan" revealed "Ice machines: ice machines are on a 3-month cleaning cycle that includes emptying the ice bin and disinfecting with a Quat Disinfectant eco-lab oasis #146 and running a clean/wash cycle through cube cell evaporator with Nickel-safe ice machine cleaner (food grade) Manitowoc de-scaler and sanitizer." A copy of the maintenance cleaning logs were requested from the MD but not provided. Review of the facility's paper policy titled,	F 812		

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F 812	Continued From page 24 "Receiving Goods," created 2/7/22, revealed, "Kitchen will receive, inspect delivery of all goods in a safe fashion and sharing quality of foods and packaging. Procedure: Ensure that all foods arc securely covered, dated, and labeled." NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring,	F 867		4/10/23

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F 867	Continued From page 25 and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on	F 867		

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F 867	Continued From page 26 high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of	F 867		

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F 867	Continued From page 27 action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, the Quality Assurance (QA) committee failed to identify quality deficiencies related to the facility's Infection Control program and take corrective action to ensure that all *Ex Order 26. 4B1* were offered and provided in accordance with recognized national standards. This failure had the potential to affect all residents who were eligible for the *Ex Order 26. 4B1* prior to 10/21. The facility failed to offer all residents, who qualified, *Ex Order 26. 4B1* or one dose of *Ex Order 26. 4B1* in accordance with nationally recognized standards, which was updated 10/21. Findings include: Review of a document provided by the facility titled "Quality Assurance and Performance Improvement (QAPI) Program," dated 11/22, indicated ". . . This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven (QAPI) program that is focused on indicators of the outcomes of care and quality of-life for our residents. . .Provide a means to measure current and potential indicators for outcomes of care and quality of life. . ." During an interview on 03/09/23 at 1:05 PM, with	F 867	1.Concerns identified through survey and plan of correction were discussed at the QAPI meeting on 3/23/23. The resident *Ex Order 26. 4B1* audit was reviewed, all residents who accepted the *Ex Order 26. 4B1* are up to date following CDC guidelines. 2.All residents have the potential to be affected by this practice. All residents will be audited to ensure they have been offered the *Ex Order 26. 4B1* according to CDC guidelines with documentation of the vaccine given or declination by the resident/resident representative. 3/10/23 3.The QAPI polices were reviewed by the Administrator and QAPI committee and no revision were needed. The QAPI committee was educated by the VP of Clinical Services on root cause analysis, reporting of concerns and trends identified through observations and audits and action plans to be developed as indicated based on the findings using the Quality Assurance and Performance Improvement and Quality Assessment and Assurance Review and CMS QAPI at a Glance. 4.The Governing body/designee will	

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F 867	Continued From page 28 the following Department Heads: Administrator, Director of Nursing (DON), Activity Director, Registered Dietician, Director of Rehabilitation, Assistant Director of Nursing, and the Infection Control Preventionist, the DON stated the *Ex Order 26. 4B1* was brought to QAPI but was not identified as a formal issue. The DON stated the facility began to audit for compliance but did not carry it through. Cross Reference: F883 *Ex Order 26. 4B1*	F 867	attend in person or via zoom the monthly QAPI meeting and review the QAPI minutes monthly for 3 months to ensure all issues brought forward are reviewed and a performance improvement plan initiated if needed.	
F 880 SS=D	NJAC 8:39-33.2(a) 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 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	F 880		4/4/23

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F 880	Continued From page 29 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 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.	F 880		

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F 880	Continued From page 30 §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 observations, interviews, and policy review, the facility failed to perform hand hygiene and glove changes during treatment to Ex Order 26. 4B1 in one of four residents (Resident (R) 3) reviewed for Ex Order 26. 4B1 in a total sample of 34 residents. This failure increased the Ex.Order 26.4(b) of the Ex Order 26. 4B1 . Findings include: Review of facility provided "Face Sheet" revealed that R3 was admitted to the facility on Ex Order 26. 4B1 with a diagnosis that included Ex Order 26. 4B1 . Further review revealed R3 was placed in Ex Order 26. 4B1 on 11/28/22. During Ex.Order 26.4(b) observation with Licensed Practical Nurse (LPN) 2 on 03/08/23 at 10:15 AM, along with LPN 4 assisting, LPN2 started with the Ex.Order , where she r Ex.Order 26.4(b)(1) the Ex Order 26. 4B1 , and then Ex.Order 26.4(b)(1) the Ex Order 26. 4B1 per physician orders, all with the same gloves. LPN2 placed all unused items back into a zip loc baggie, then removed her gloves and washed her hands. LPN2 placed on new gloves, after getting a zip loc baggie from the treatment cart and loosened the old dressing on R3's Ex Order 26. 4B1 . Wearing the same gloves, LPN2 went back to the overbed table and opened all the treatment packages out of the zip loc baggie. Then she helped LPN4 re-position R3	F 880	Directed Plan of Correction R3 had a Ex Order 26. 4B1 assessment was completed by the Ex Order 26. 4B1 care NP completed on 3/10/23 and 3/17/23 and there were Ex.Order 26.4(b)(1) . LPN2 was given one on one education by the Infection Control nurse on hand hygiene with glove changes and the correct procedure for Ex.Order 26.4(b)(1) including Ex.Order 26.4(b)(1) of the Ex Order 26. 4B1 LPN 4 was given one on one education by the Infection Control nurse on hand hygiene with changes and the correct procedure for Ex.Order 26.4(b)(1) including Ex.Order 26.4(b)(1) of the Ex Order 26. 4B1 CNA 1 no longer works at the facility. 2 All residents have the potential to be affected by this practice. An audit was completed by the Director of Nursing of all residents who have a Ex.Order 26.4(b)(1) by LPN2 in the last two weeks, to ensue Ex.Ord of the Ex Order 26. 4B1 is present. 3. The policy titled Ex Order 26. 4B1 Care was reviewed by the Infection Control nurse, Director of Nursing and the Medical Director and no revisions were needed. The consultant will educate on the following; Topline staff and Infection Preventionist using:	

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F 880	Continued From page 31 in the bed, all with the same gloves. After re-positioning R3, LPN2 finished Ex.Order 26.4(b)(1) d the Ex Order 26. 4B1, patted dry and Ex.Order 26.4(b)(1) Ex Order 26. 4B1 per physician orders, all with the same gloves. After Ex.Order 26.4(b)(1) the Ex Order 26. 4B1, LPN2 placed all unused items back into the zip loc baggie, changed her gloves, and washed her hands. LPN2 placed on new gloves and obtained items in a zip loc baggie for R3's Ex Order 26. 4B1 on Ex Order Ex Order 26. 4B1. LPN2 Ex.Order 26.4(b)(1) the Ex Order 26. 4B1 and Ex.Order 26.4(b)(1) per physician orders; however, with the same gloves, LPN2 was observed digging into her right pocket for a pen to write the date on the Ex.Order 26.4(b)(1) LPN2, then replaced all unused items back into the zip loc baggie. This all was done wearing the same gloves. LPN2 then removed her gloves, washed her hands, and applied a new set of gloves before she obtained from the treatment cart the zip loc baggie for R3's Ex Order 26. 4B1 on the Ex Order 26. 4B1. This was a new Ex Order 26. 4B1 that was Ex.Order 26.4(b)(1) present. LPN4 said that she would call the NP and get an order for the Ex Order 26. 4B1; however, in the meantime, LPN2 cleaned the Ex Order 26. 4B1 with Ex Order 26. 4B1 solution, placed Ex Order 26. 4B1 on the Ex Order 26. 4B1 and Ex.Order 26.4(b)(1) over the Ex Order 26. 4B1, all with the same gloves. LPN2 removed her gloves, washed her hands, and obtained supplies from the treatment cart for R3's Ex Order 26. 4B1. Upon returning to the room, LPN2 placed on new gloves, placed items from a zip loc baggie onto the overbed table, then assisted with moving R3 up in the bed, unfastened R3's Ex Order 26. 4B1, and noticed that R3 had a Ex Order 26. 4B1 Ex.Order 26. LPN2 removed her gloves at this point and replaced them with new gloves. LPN4 went to get the Ex Order 26. 4B1 Certified Nursing Assistant (CNA) CNA1, who arrived in R3's bedroom already with	F 880	a. Nursing Home Infection Preventionist Training Course: a. module 1, infection prevention and control program b. module 5, outbreaks c. module 4, infection surveillance d. module 7, hand hygiene e. module 6A, principles of standard precautions f. module 6B, principles of transmission-based precautions Frontline staff using; a. CDC Ex Order 26. 4B1 prevention messages for front line long-term care staff: a. Keep Ex Order 26. 4B1 out! b. Clean hands c. Closely monitor residents d. Use PPE correctly for Ex Order 26. 4B1 All staff using; a. Nursing Home Infection Preventionist Training Course: a. module 7, hand hygiene b. module 6A, principles of standard precautions c. module 6B, principles of transmission-based precautions 4. To ascertain the effectiveness of the education competencies will be completed The Infection Control nurse will complete a Ex.Order 26.4(b)(1) competency on each frontline licensed nurse in one month, then 30% of frontline licensed nurses for 3 months The Infection Control nurse will complete hand hygiene competencies on 30 % of staff every month for 3 months	

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F 880	Continued From page 32 her Personal Protective Equipment (PPE) on, including gloves. CNA1 obtained all supplies and began to Ex.Order 26.4(b)(1) of R3. While cleaning R3, CNA1 had Ex.Order 26.4(b)(1) on her gloves, so CNA1 was observed wiping off her gloves, kept wiping the resident, without changing her current gloves. She then pat dried the resident, and went to the bathroom to empty the water, all with the same gloves. CNA1 then brought back the basin, placed it in R3's nightstand, then changed her gloves. After the Ex.Order 26.4(b)(1) CNA1 was finished, the LPN2 went on to address R3's *Ex Order 26. 4B1*. The Ex.Order 26.4(b)(1) by CNA1 while cleaning up R3. LPN2 changed her gloves, applied new gloves, and cleaned the bigger than a *Ex Order 26. 4B1* with undermining all the way around the Ex Order 26. 4B1, along with Ex Order 26. 4 in the Ex Order 26. 4B1 bed. With the same gloves, LPN2 applied *Ex Order 26. 4B1* powder to the Ex Order 26. 4B1 bed, placed Ex.Order 26.4(b)(1) on the Ex.Order 2, all without changing her gloves. With the same gloves, she placed unused items in the zip loc baggie, and then assisted CNA1 in adjusting R3 in the bed again. With the same gloves, LPN2 Ex.Order 26.4(b)(1) on the *Ex Order 26. 4B1*, and then went through the zip loc baggie, pulling out some items. She then changed her gloves, cleaned the Ex Order 26. 4B1 with *Ex Order 26. 4B1*, patted the Ex Order 26. 4B1 dry, and applied *Ex Order 26. 4B1* on the Ex.Order 26.4(b)(1) on the Ex Order 26. 4B1. Without changing her gloves, LPN2 dug into her right pants pocket, obtained a pen and wrote the date on the Ex.Order 26.4(b)(1) She then removed her gloves and washed her hands. Then returned the unused items into the zip loc baggie, placing the baggie in the treatment cart. Review of the facility provided "Relias Transcript"	F 880	encompassing all shifts. The results of the competencies will be reported at the QAPI meeting. Any discrepancies noted during the competencies will be corrected immediately with re-education and/or counseling of the individual.	

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F 880	Continued From page 33 for [redacted] CNA1 revealed that she did the on-line training for hand hygiene on 07/22/22 without an agenda attached. Review of the "Clinical Competency Validation: Hand Hygiene," provided by the facility and dated 03/29/22, revealed that LPN2 met competence. During further review, there was no agenda attached. Review of the "Center for Disease Control (CDC) Train Module Seven: Hand Hygiene," facility provided and dated 07/30/22, revealed that LPN2 completed the training, but no agenda attached. Review of the "Hand Hygiene In-Service," facility provided and dated 12/21/22, revealed that LPN2 attended; however, no agenda attached. During an interview on 03/08/23 at 2:25 PM, LPN2 stated that she would change her gloves between treatments, when moving to a new [redacted]. During an interview on 03/08/23 at 2:30 PM, LPN4 confirmed that after removing an old dressing, gloves should be changed prior to cleaning the [redacted]. Said that gloves should be changed after cleaning the [redacted] and before applying a new dressing. Interview with the Assistant Director of Nursing (ADON) on 03/08/23 at 4:02 PM, confirmed that staff are to change gloves when going from a dirty to a clean area. Interview with the Director of Nursing (DON) on 03/08/23 at 4:26 PM, confirmed that gloves should be changed when going from a dirty area	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	**3000 HILLTOP ROAD WHITING, NJ 08759**

(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 880	Continued From page 34 to a clean area Review of the facility provided policy titled, "[redacted] Care," revised 05/21, revealed "The purpose of this procedure is to provide guidelines for the care of [redacted] to promote healing. Put on clean gloves. Loosen tape and remove dressing. Pull glove over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. Wear clean gloves for holding gauze to catch irrigation solutions that are poured directly over the [redacted]. Wear clean gloves when physically touching the [redacted] or holding a moist surface over the [redacted]."	F 880		
F 883 SS=F	NJAC 8:39-19.4(a) Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		4/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING _____ B. WING _____	03/09/2023

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F 883	Continued From page 35 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the	F 883	1.On 3/9/23 After providing education to resident R 33 regarding the [redacted] Ex Order 26. 4B1 Ex.Order 26.4(b)(1) the resident Ex.Order 26.4(b)(1)	

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COMPLETE CARE AT WHITING	3000 HILLTOP ROAD WHITING, NJ 08759

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F 883	Continued From page 36 facility failed to offer five of five residents (Resident (R) 60, R18, R33, R29, and R43) reviewed for Ex Order 26. 4B1 and/or their representatives out of a total sample of 34 residents, the opportunity for the resident to be Ex Order 26. 4B1 in accordance with nationally recognized standards. The facility failed to offer R60, R18, R33, and R29 the opportunity to be Ex Order 26. 4B1 with Ex Order 26. 4B1, prior to 10/21/21. The facility failed to offer R43 the opportunity to be Ex Order 26. 4B1 with Ex Order 26. 4B1 prior to 10/21/21. The facility failed to offer all five residents with Ex Order 26. 4B1 or one dose of Ex Order 26. 4B1 in accordance with nationally recognized standards. This practice had the potential to increase the risk for these residents to contract Ex Order 26. 4B1. Findings include: 1. Review of R60's EMR "Admission Record," located under the "Profile" tab, indicated the resident was initially admitted to the facility on Ex Order 26. 4B1 and most recently admitted on Ex Order 26. 4B1. The resident was Ex.Order 26.4(b)(1) at the time of his admission to the facility. Review of R60's EMR Ex Order 26. 4B1 located under the Ex Order 26. 4B1 tab, indicated the resident received Ex Order 26. 4B 23 on 11/16/17. Review of a document provided by the facility titled "Resident Ex Order 26. 4B1 Informed Consent," handwritten as dated 04/21/22, indicated the resident received a Ex Order 26. 4B1 on 11/16/17 but the form did not identify which Ex Order 26. 4B1 the resident	F 883	the immunization, a copy of the Ex.Order 26.4(b)(was placed in her chart. On 3/14/23 After providing education and consent obtained for resident R 60, they were administered the Ex Order 26. 4B1. On 3/14/23 After providing education and consent obtained for resident R 43, they were administered the Ex Order 26. 4B1. On 3/16/23 After providing education and consent obtained for resident R 29, they were administered the Ex Order 26. 4B1. On 3/21/23 After providing education and consent obtained for resident R 18, they were administered the Ex Order 26. 4B1. On 3/10/23 the Infection Preventionist, MDS coordinator and DON were educated on the updated recommendations from the CDC regarding Ex Order 26. 4B1. The Ex Order 26. 4B1 consent has been updated to reflect the current recommendations from the CDC. 2.All residents have the potential to be affected by this practice. The Infection Preventionist will perform 100% chart audit and identify any other resident who may be at risk for this practice and provide the appropriate Ex Order 26. 4B1. All data will be maintained on a spread sheet, with resident identifiers, Ex Order 26. 4B1 names and dates received along with future due dates. 3/10/23 3.Review of the policy titled	

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	315293	A. BUILDING _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	**3000 HILLTOP ROAD WHITING, NJ 08759**

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F 883	Continued From page 37 previously received nor did the form identify what Ex Order 26. 4B1 the resident was offered. 2. Review of R18's EMR "Admission Record," located under the "Profile" tab, indicated the resident was admitted to the facility on Ex Order 26. 4B1. The resident was Ex.Order 26.4(b)(1) at the time of Ex Order admission to the facility. Review of R18's EMR Ex Order 26. 4B1 located under the "Immun" tab, indicated the resident received Ex Order 26. 4B1 on 11/18/18. Review of a document provided by the facility titled "Resident Ex Order 26. 4B1 Informed Consent," handwritten as dated 04/21/22, indicated the resident received a Ex Order 26. 4B1 on 11/18/18 but the form did not identify which vaccination the resident previously received nor did the form identify what Ex Order 26. 4B1 the resident was offered. 3. Review of R33's EMR "Admission Record," located under the "Profile" tab, indicated the resident was initially admitted to the facility on Ex Order 26. 4B1 and most recently admitted on Ex Order 26. 4B1. The resident was Ex.Order 26.4(b)(1) at the time of her admission to the facility. Review of R33's EMR Ex Order 26. 4B1 located under the Ex Order 26. 4B1 tab, indicated the resident received Ex Order 26. 4B1 on 12/24/20. 4. Review of R29's EMR "Admission Record," located under the "Profile" tab, indicated the resident was initially admitted to the facility on Ex Order 26. 4B1 and most recently admitted on Ex Order 26. 4B1. The resident was Ex.Order 26.4(b)(1) at the time of Ex Order admission to the facility.	F 883	Ex Order 26. 4B1 was reviewed by the Medical Director and the Director of Nursing, and not revisions were needed. the Medical Director will educate the Director of Nursing, the Infection Preventionist and Registered Nurse staff on the CDC guide lines for Ex Order 26. 4B1 for the nursing home population and the Ex Order 26. 4B1 consent. Resident/resident representative who decline the Ex Order 26. 4B1 will be re-approached annually. 4.To ascertain the effectiveness of the education an audit was developed. The Infection Preventionist/designee will screen all new admissions within 5 working days of the admission for Ex Order 26. 4B1 status for 6 months. Ex Order 26. 4B1 will be provided according to the CDC recommendations unless the resident/resident representative declines. Ex Order 26. 4B1 status will be reported out at the monthly QAPI meetings.	

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F 883	Continued From page 38	F 883		

Review of R29's EMR Ex Order 26. 4B1 located under the Ex Order 26. 4B1 tab, indicated the resident received Ex Order 26. 4B1 on 01/14/20.

5. Review of R43's EMR "Admission Record," located under the "Profile" tab, indicated the resident was re-admitted to the facility on Ex Order 26. 4B1. The resident was Ex.Order 26.4(b)(1) at the time of Ex Order admission to the facility.

Review of R43's EMR Ex Order 26. 4B1 located under the Ex Order 26. 4B1 tab, indicated the resident received Ex Order 26. 4B1 on 03/14/19.

During an interview on 03/06/23 at 3:12 PM, the Director of Nursing (DON) stated she did not know the newest Ex Order 26. 4B1 recommendations from the CDC.

During an interview on 03/06/23 at 3:27 PM, the Infection Control Preventionist (ICP) stated he was aware the Ex Order 26. 4B1 were important to residents who were Ex.Order 26.4(b)(1) The ICP stated he was not aware of the updated CDC recommendations to offer either the Ex Order 26. 4B1 or Ex Order 26. 4B1.

During an interview on 03/07/23 at 9:49 AM, the ICP stated he did not do any audit of the current residents and whether they had received the most current recommended Ex Order 26. 4B1.

During an interview on 03/07/23 at 9:55 AM, the Medical Director stated the facility will periodically check to see if the residents were offered the Ex Order 26. 4B1 or Ex Order 26. 4B1. The Medical Director stated his expectations for the facility was to ensure the

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F 883	Continued From page 39 residents were offered Ex Order 26. 4B1 or Ex Order 26. 4B1. The Medical Director stated he did not expect the facility to offer the residents either the Ex Order 26. 4B1 or one dose of Ex Order 26. 4B1 since these were new recommendations from the CDC. During an interview on 03/08/23 at 10:09 AM, the Minimum Data Set (MDS) Coordinator, who was the previous ICP, stated she did not complete any audit for the *Ex Order 26. 4B1*. The MDS Coordinator stated she was unaware of the updated CDC recommendations for the Ex Order 26. 4B1 or the Ex Order 26. 4B1. The MDS Coordinator confirmed there was no specific information in the consents for R60 and R18 did not identify which Ex Order 26. 4B1 the residents previously received nor did the form identify what *Ex Order 26. 4B1* the residents were offered. Review of the CDC recommendations, revised on 02/13/23, indicated "...CDC recommends *Ex Order 26. 4B1* for all adults Ex Order 26.4(b)(1) who have not previously received any *Ex Order 26. 4B1* +, CDC recommends you. . .Give 1 dose of Ex Order 26. 4B1 or Ex Order 26. 4B1. . .If Ex Order 26. 4B1 is used, this should be followed by a dose of Ex Order 26. 4B1 at least 1 year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. . .If Ex Order 26. 4B1 is used, a dose of Ex Order 26. 4B1 is NOT indicated. . . For adults 65 years or older who have only received Ex Order 26. 4B1, CDC recommends you. . .Give 1 dose of Ex Order 26. 4B1 or Ex Order 26. 4B1. The Ex Order 26. 4B1 or Ex Order 26. 4B1 dose should be administered at least 1 year after the most recent Ex Order 26. 4B1 vaccination. Regardless of if Ex Order 26. 4B1 or Ex Order 26. 4B1 is given, an additional dose of Ex Order 26. 4B1 is not recommended since they already	F 883		

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F 883	Continued From page 40 received it. For adults Ex.Order 26.4(b)(1) who have only received [redacted], CDC recommends you either. . .Give 1 dose of [redacted] at least 1 year after [redacted]. . .or Give 1 dose of [redacted] at least 1 year after [redacted]. . ." Review of a document provided by the facility titled "Pneumococcal Vaccine," dated 01/22, indicated ". . .All residents will be offered *Ex Order 26. 4B1* to aide in preventing *Ex Order 26. 4B1* infections. . .Prior to or upon admission, residents will be assessed for eligibility to receive the *Ex Order 26. 4B1* series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. . .Administration of the *Ex Order 26. 4B1* or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the *Ex Order 26. 4B1*. . ." NJAC 8:39-19.4(i)	F 883		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061534	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	3000 HILLTOP ROAD WHITING, NJ 08759

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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 observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 13 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1.There were no care issues reported on the thirteen shifts that were identified. 2.All residents have the potential to be affected by this practice. The Director of Nursing/designee reviewed the last 30 days of the C.N.A. staffing report. The interdisciplinary team reviewed the grievance logs and care conference meetings and no care issues were identified. 3.Administrator in – serviced the staffing coordinator regarding the requirement for S560 to ensure C.N.A. staffing needs are reviewed daily and addressed as needed to meet the staffing requirement.	4/10/23

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

Electronically Signed | 03/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: 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. The surveyor requested staffing for the weeks of 2/19/2023 to 2/25/2023 and 2/26/2023 to 3/04/2023. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -02/19/23 had 12 CNAs for 110 residents on the day shift, required 14 CNAs. -02/20/23 had 9 CNAs for 110 residents on the day shift, required 14 CNAs. -02/21/23 had 11 CNAs for 109 residents on the day shift, required 14 CNAs. -02/22/23 had 12 CNAs for 109 residents on the day shift, required 13 CNAs. -02/24/23 had 11 CNAs for 108 residents on the day shift, required 13 CNAs.	S 560	Recruitment efforts are in place to assist the facility in recruiting, C.N.A. receive sign on bonuses, referral bonuses, reimbursement for C.N.A. tuition, and transportation service from certain locations, Facility also has contracts with agencies to recruit C.N.As. The Director of Nursing/designee also reviews staff attendance records to ensure that excessive absences are addressed accordingly. 4.The Administrator/designee will have weekly meetings with the staffing coordinator to review staffing schedules, needs, and the efficacy of the systems in place to fill needs. The findings of the audits will be presented at the Quarterly QAPI meetings x 3 meetings or until a timeframe determined by the QAPI members.	

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S 560	Continued From page 2 -02/25/23 had 10 CNAs for 108 residents on the day shift, required 13 CNAs. -02/26/23 had 10 CNAs for 108 residents on the day shift, required 13 CNAs. -02/27/23 had 12 CNAs for 110 residents on the day shift, required 14 CNAs. -02/28/23 had 12 CNAs for 110 residents on the day shift, required 14 CNAs. -03/01/23 had 11 CNAs for 110 residents on the day shift, required 14 CNAs. -03/02/23 had 11 CNAs for 108 residents on the day shift, required 13 CNAs. -03/03/23 had 12 CNAs for 108 residents on the day shift, required 13 CNAs. -03/04/23 had 9 CNAs for 107 residents on the day shift, required 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
315293 Y1	A. Building B. Wing Y2	4/11/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	3000 HILLTOP ROAD WHITING, NJ 08759

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 F0578	Correction	ID Prefix F0580	Correction	ID Prefix F0641	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.20(g)	Completed
LSC	04/10/2023	LSC	04/10/2023	LSC	04/10/2023
ID Prefix F0657	Correction	ID Prefix F0756	Correction	ID Prefix F0758	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed
LSC	04/10/2023	LSC	04/10/2023	LSC	04/10/2023
ID Prefix F0812	Correction	ID Prefix F0867	Correction	ID Prefix F0880	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.75(c)(d)(e)(g)(2)(i)(ii)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/10/2023	LSC	04/10/2023	LSC	04/04/2023
ID Prefix F0883	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(d)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/10/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
3/9/2023	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061534 Y1	A. Building B. Wing Y2	4/11/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	3000 HILLTOP ROAD WHITING, NJ 08759

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/10/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/9/2023	☐ 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
	315293	A. BUILDING **02** B. WING _____	**03/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	**3000 HILLTOP ROAD** **WHITING, NJ 08759**

(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 on 03/08/2023. The facility was found to be in 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 New Jersey Department of Health, Health Facility Survey and Field Operations on 03/08/23 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 at Whiting is a one story building that was built in 1992. It is composed of Type V-111 protected construction. The facility is divided into nine smoke zones. The generator does 100 % of the building as per the Maintenance Director. The current occupied beds are 106 of 190.	K 000		

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

Electronically Signed | 03/17/2023

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