

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Complaint #: NJ174825, NJ175184, NJ176084, NJ179637, NJ182983, NJ183967, NJ184223 STANDARD SURVEY: 3/23/25 to 3/27/25 CENSUS: 109 SAMPLE SIZE: 23 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000			
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to provide necessary treatment services, consistent with professional standards of clinical practice by not a.) securing medications during medication administration observation for 1 of 3 nurses; b.) notifying a physician regarding a resident's refusal of medication for [REDACTED]	F 658	Residents affected by deficient practice: The facility failed to provide necessary treatment services, consistent with professional standards of clinical practice by not a.) securing medications during medication administration observation for 1 of 3 nurses; b.) notifying a physician regarding a resident's refusal of medication for [REDACTED]	5/21/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/17/2025

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

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F 658	<p>Continued From page 1</p> <p>Reference: New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."</p> <p>Reference New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; "The practice of nursing as a licensed practical nurse is defined as performing task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist."</p> <p>This deficient practice was identified by the following:</p> <p>1. A review of the Admission Record face sheet (admission summary) indicated that Resident #31 was admitted to the facility with the diagnoses which included but were not limited to: <i>NJ Ex Order 26. 4B1</i></p>	F 658	<p><i>NJ Ex Order 26. 4B1</i></p> <p>Resident #31 and Resident #81 were monitored for any <i>NJ Exec Order 26.4b1</i> with <i>NJ Exec Order 26.4b1</i>.</p> <p>LPN #1 was reeducated on 3/25/2025 by the Director of Nursing to make sure that the physician is notified in the event a resident refuses medication in addition to reeducation on the facility's Resident Rights Regarding Treatment and Avance Directives policy.</p> <p>LPN #1 was reeducated on 3/25/2025 by the Director of Nursing to properly dispose and discard medications as requirement in the event a resident refuses in addition to reeducation on the facility's Medication Storage Policy and the facility's "Destruction of Unused Drugs" policy.</p> <p>RN #1 was reeducated on 3/25/2025 by the Director of Nursing on the requirement to sign the TAR after administering the treatment or <i>NJ Ex Order 26. 4B1</i> as ordered for the resident and to notify the physician and document in the event a resident refuses and on the facility's Resident Rights Regarding Treatment and Avance Directives policy.</p> <p>RN #1 was reeducated on 3/25/2025 by the Director of Nursing on facility's "Use of Assistive Device" policy.</p> <p>The Director of Nursing/Designee</p>	

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F 658	<p>Continued From page 2</p> <p><i>NJ Ex Order 26. 4B1</i></p> <p>On 3/24/25 at 9:10 AM, during medication administration observation for Resident #31, the surveyor observed Resident #31 lying in bed. The surveyor observed the <i>U.S. FOIA (b) (6)</i> (LPN #1) offer Resident #31 the medication <i>NJ Ex Order 26. 4B1</i>. LPN #1 placed the medication, unsecured, on top of the medication cart and went into the resident's room and bathroom while the medication was out of the LPN's view. The surveyor interviewed LPN #1 and asked her if all medications should be secured in the cart and the LPN confirmed that all medications should be secured in the cart. The surveyor then asked LPN #1 why she left the <i>NJ Ex Order 26. 4B1</i> on the top of the medication cart and did not secure it in the cart, and the LPN admitted that she should have locked the medication in the medication cart because another resident could have taken it from on top of the cart.</p> <p>A review of the Physicians Orders (PO) dated <i>NJ Exec Order 26.40</i> reflected an order for <i>NJ Ex Order 26. 4B1</i>.</p> <p>A review of the <i>NJ Exec Order 26.4b1</i> Medication Administration Record (MAR) revealed that Resident #31 had <i>NJ Exec Order 26.1</i> the <i>NJ Ex Order 26. 4B1</i>. The medication was <i>NJ Exec Order 26.1</i> on the following dates: <i>NJ Ex Order 26. 4B1</i>,</p>	F 658	<p>conducted an audit for current residents to ensure that professional standards are followed as appropriate and according to the above facility policies.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the Director of Nursing/Designee initiated reeducation for all Licensed Nursing Staff to ensure meeting professional standards of clinical practice. The reeducation included the following policies: Resident Rights Regarding Treatment and Avance Directives, Medication Storage Policy, Destruction of Unused Drugs, and Use of Assistive Device.</p> <p>Measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>The Director of Nursing/Designee will conduct audits of resident medical charts to ensure that professional standards are followed as required to ensure compliance with the following policies: Resident Rights Regarding Treatment and Avance Directives, Medication Storage, Destruction of Unused Drugs, and Use of Assistive Device. The Director of Nursing/Designee will conduct one weekly</p>	

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F 658	<p>Continued From page 3</p> <p><i>NJ Ex Order 26. 4B1</i></p> <p>[REDACTED]</p> <p>The surveyor reviewed Resident #31's Progress Notes (PN) and there was documentation that the resident's <u>U.S. FOIA (b) (6)</u> was notified one time on ^{NJ Exec Order 26. 4B1} at 9:59 AM, regarding the resident's ^{NJ Exec Order 26. 4B1} of the medication, however there was no documentation regarding the physician's response to the ^{NJ Exec Order 26. 4B1}.</p> <p>There was also documentation in the PN on ^{NJ Exec Order 26. 4B1} at 10:34 AM, that the resident ^{NJ Exec Order 26. 4B1} the medication, however the note did not indicate that the physician was made aware.</p> <p>The surveyor reviewed the Physician Progress Notes (PPN) for ^{NJ Exec Order 26. 4B1}, which included notes documented on <i>NJ Ex Order 26. 4B1</i>. The notes did not include documentation that the physician was aware that the resident was ^{NJ Exec Order 26. 4B1} the <i>NJ Ex Order 26. 4B1</i>.</p> <p>A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated ^{NJ Exec Order 26. 4B1} that the resident was on <i>NJ Ex Order 26. 4B1</i>. Interventions included to: administer <i>NJ Ex Order 26. 4B1</i> as ordered by physician and monitor for side effects and effectiveness every shift; and to monitor/document/report as needed (PRN) adverse reactions of <i>NJ Ex Order 26. 4B1</i> which included; <i>NJ Ex Order 26. 4B1</i></p> <p>[REDACTED]</p>	F 658	<p>audit of three resident medical charts for four weeks, then two audits monthly for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.</p>		

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F 658	<p>Continued From page 4</p> <p><i>NJ Ex Order 26. 4B1</i></p> <p>[REDACTED]. The ICCP did not indicate that the resident had behaviors of non-compliance with medication usage.</p> <p>On 3/24/25 at 11:55 AM, the surveyor interviewed LPN #1, who stated that if a resident <i>NJ Ex Order 26. 4B1</i> a medication on consecutive days, the assigned nurse was expected to call and notify the physician. LPN #1 stated that if the resident consistently <i>NJ Ex Order 26. 4B1</i> the medication by day three, the nurse was responsible to call the physician to obtain an alternate medication or to get a discontinuation order for the medication.</p> <p>On 3/24/25 at 1:38 PM, the surveyor interviewed the <i>U.S. FOIA (b) (6)</i> who stated that if the resident <i>NJ Ex Order 26. 4B1</i> a medication after three days, the physician should have been notified to find out if an alternative could be ordered or to see if the medication could be discontinued. The <i>U.S. FOIA (b) (6)</i> continued to explain that there should have been documentation in the progress notes that the resident had been <i>NJ Ex Order 26. 4B1</i> for <i>NJ Ex Order 26. 4B1</i> in <i>NJ Ex Order 26. 4B1</i> and there also should have been documentation that the physician was made aware and what the physician wanted to do about the <i>NJ Ex Order 26. 4B1</i>.</p> <p>On 3/25/25 at 11:53 AM, the surveyor interviewed the <i>U.S. FOIA (b) (6)</i>, who stated that Resident #31 was <i>NJ Ex Order 26. 4B1</i> for <i>NJ Ex Order 26. 4B1</i>. The <i>U.S. FOIA (b) (6)</i> stated that she knew that while the resident was in the <i>NJ Ex Order 26. 4B1</i> that the resident was <i>NJ Ex Order 26. 4B1</i>, however she could not remember if she was notified that the resident <i>NJ Ex Order 26. 4B1</i> the <i>NJ Ex Order 26. 4B1</i> at this facility. The</p>	F 658			

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F 658	<p>Continued From page 5</p> <p>^{U.S. FOIA (b) (6)} stated that if she was notified, she could have recommended an alternative such as ^{NJ Ex Order 26. 4B1}, because you cannot force resident to take something that they did not want to.</p> <p>On 3/27/25 at 9:29 AM, the surveyor interviewed the ^{U.S. FOIA (b) (6)}, who stated that when she conducted the medical record review (MRR), she reviewed the MAR, physician orders, checked parameters and documented any discrepancies. The ^{U.S. FOIA (b) (6)} stated that she conducted an MRR review for Resident #31 and sent a separate report to the ^{U.S. FOIA (b) (6)} or ^{NJ Ex Order 26. 4B1}, regarding the resident ^{NJ Ex Order 26. 4B1}. The ^{U.S. FOIA (b) (6)} stated that she did not know why the ^{U.S. FOIA (b) (6)} stated that she was not aware the resident ^{NJ Ex Order 26. 4B1} the medication.</p> <p>A review of the ^{US FOIA (b)(6)} Report ^{NJ Ex Order 26. 4B1} dated ^{NJ Ex Order 26. 4B1} included the ^{U.S. FOIA (b) (6)} recommendations: This resident has been ^{NJ Ex Order 26. 4B1}. Please consider switching to an ^{NJ Ex Order 26. 4B1}.</p> <p>On 3/27/25 at 10:14 AM, the ^{U.S. FOIA (b) (6)} stated that the facility reviewed and acted upon the ^{U.S. FOIA (b) (6)} recommendations on ^{NJ Ex Order 26. 4B1} however they did not see the second page which contained the recommendations regarding the resident's ^{NJ Ex Order 26. 4B1} of the ^{NJ Ex Order 26. 4B1}, which was acted upon on ^{NJ Ex Order 26. 4B1} after surveyor inquiry. The ^{U.S. FOIA (b) (6)} stated that the ^{U.S. FOIA (b) (6)} switched the medication to ^{NJ Ex Order 26. 4B1}.</p> <p>2. The Admission Record face sheet indicated that Resident #81 was admitted to the facility with</p>	F 658		

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F 658	<p>Continued From page 6</p> <p>the diagnoses which included but were not limited to; <i>NJ Ex Order 26. 4B1</i></p> <p>[REDACTED]</p> <p>[REDACTED]. The MDS also indicated that the resident had a <i>NJ Ex Order 26. 4B1</i> and was at risk for development of <i>NJ Ex Order 26. 4B1</i>.</p> <p>A review of the PO dated <i>NJ Exec Order 26</i>, reflected an order for <i>NJ Ex Order 26. 4B1</i> and to maintain and check for placement every shift. The <i>NJ Ex Order 26</i> were to be removed for care every shift for <i>NJ Ex Order 26. 4B1</i> to check for <i>NJ Exec Order 26.4b</i></p> <p>On 3/23/25 at 11:52 AM, the surveyor observed the resident lying in bed and was not wearing <i>NJ Ex Ord</i>.</p> <p>On 3/24/25 at 11:30 AM, the surveyor observed Resident #81 lying in bed. The resident was interviewed at that time and stated that they were not wearing any <i>NJ Ex Order 26. 4B1</i>. The resident lifted the blankets and showed the surveyor.</p> <p>A review of the resident's ICCP included a focus area dated <i>NJ Exec Order 26</i>, that the resident had <i>NJ Exec Order 26. 4B1</i>. A review of the intervention dated <i>NJ Exec Order 26</i>, included that the resident was to wear <i>NJ Ex Order 26. 4B1</i> while in bed and check placement every shift.</p> <p>On 3/24/25 at 11:44 AM, the surveyor interviewed the resident's Certified Nursing Assistant (CNA #1), who stated that Resident #81 was <i>NJ Exec O</i> and <i>NJ Exec Order 26.4b1</i> and <i>NJ Exec Order 26.4b1</i> CNA #1 stated that the resident</p>	F 658			

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F 658	<p>Continued From page 7</p> <p><i>NJ Ex Order 26. 4B1</i></p> <p>[REDACTED]</p> <p>A review of the Treatment Administration Record (TAR) dated <i>NJ Exec Order 26.1</i>, indicated that the nurse had signed that the <i>NJ Ex Order 26. 4B1</i> were in place on the resident.</p> <p>On 3/25/25 at 11:45 AM, the surveyor observed Resident #81 not wearing <i>NJ Ex Order 26. 4B1</i> as ordered by the physician. The surveyor interviewed the <i>U.S. FOIA (b) (6)</i> (RN #1), who accompanied the surveyor to the resident's room, and RN #1 stated that the <i>NJ Ex Order 26. 4B1</i> must be in the laundry. RN #1 then went to a closet in the hallway and obtained the <i>NJ Ex Order 26. 4B1</i>. RN #1 had no explanation as to why she had signed in the TAR that the resident's <i>NJ Ex Order 26. 4B1</i> were in place when they were not on.</p> <p>On 3/27/25 at 10:14 AM, the surveyor interviewed the <i>U.S. FOIA (b) (6)</i>, who stated that the <i>NJ Ex Order 26. 4B1</i> should be applied as ordered by the physician and that if the resident refused to wear them, it should be documented in the PN.</p> <p>3. On 3/24/25 at 9:10 AM, the surveyor conducted a medication observation on the <i>NJ Ex Order 26. 4B1</i> with LPN #1.</p> <p>The surveyor observed a resident <i>NJ Exec Order 26. 4B1</i> a <i>NJ Ex Order 26. 4B1</i>. After the resident's <i>NJ Exec Order 26. 4B1</i> LPN #1 returned to the medication cart and threw the medication in the trash can. The surveyor asked LPN #1 what the process was for proper disposal of medication, and the LPN stated that she should have disposed the medication into the</p>	F 658			

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F 658	<p>Continued From page 8</p> <p>drug buster (used for pill disposal, destroys prescription medications safely, and safe disposal of medications). When asked why she threw the medication in the trash can, LPN #1 stated that she improperly disposed of the medication because she ^{NJ Exec Order 26.4b1}.</p> <p>On 3/27/25 at 10:14 AM, the surveyor interviewed the ^{U.S. FOIA (b)}, who stated that medication should have been disposed in the drug buster not the trash can.</p> <p>A review of the facility's "Medication Storage" policy dated 9/1/24, included that during medication pass, medications must be under the direct observation of the person administering the medications and locked in the medication storage area/cart.</p> <p>A review if the facility's "Resident Rights Regarding Treatment and Advance Directives" policy dated 9/1/24, included that should a resident refuse treatment of any kind, the facility would document the following in the resident's chart: what the resident refused; the reason for the refusal; how the resident was educated regarding the consequences of the refusal; the offering of alternative treatments; the continuation of providing all other services; that the physician was notified of the refusal and the resident's response to education/offering of alternatives...</p> <p>A review of the facility's "Use of Assistive Device" policy dated 9/1/24, included that use of assistive device will be based on the resident's comprehensive care plan and that the nurse with responsibility for the resident would monitor for consistent use of the device. Refusals of use would be documented in the resident's medical</p>	F 658			

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F 677 SS=E	NJAC 8:39-11.2(b); 27.1(a); 29.4(h) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint # NJ175184, NJ176084, NJ179637 Based on observations, interviews, and review of pertinent facility documents, the facility failed to ensure residents who <i>NJ Ex Order 26. 4B1</i>	F 677	Residents affected by deficient practice: The facility failed to ensure residents who required assistance with their <i>NJ Ex Order 26. 4B1</i>	5/21/25	

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F 677	<p>Continued From page 10</p> <p><i>NJ Ex Order 26. 4B1</i></p> <p>1. On 3/23/25 at 10:10 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1), who stated the unit today had five certified Nurse Aides (CNA) for 48 residents.</p> <p>On 3/23/25 at 10:26 AM, during the initial tour of the unit, the surveyor interviewed Resident #65 who was lying in their bed. The resident stated that they were <i>NJ Ex Order 26. 4B1</i>. Resident #65 stated that they had to use <i>NJ Ex Order 26. 4B1</i>. The resident then showed the surveyor the <i>NJ Ex Order 26. 4B1</i>. The resident then stated that they had not been <i>NJ Ex Order 26. 4B1</i>.</p> <p>A review of Resident #65's most recent quarterly Minimum Data Set (MDS), an assessment tool dated <i>NJ Ex Order 26. 4B1</i>, revealed that the resident had a brief interview for mental status (BIMS) score or <i>NJ Ex</i> out of 15, which indicated a <i>NJ Ex Order 26. 4B1</i>. The MDS further revealed that the resident was <i>NJ Ex Order 26. 4B1</i>.</p> <p>On 3/24/25 at 9:45 AM, the surveyor observed Resident #65 lying in bed in their room. The resident stated, <i>NJ Ex Order 26. 4B1</i>. "The resident then stated that they were <i>NJ Ex Order 26. 4B1</i>".</p> <p>On 3/25/25 10:30 AM, the surveyor interviewed CNA #1, who stated that residents' <i>NJ Ex Order 26. 4B1</i></p>	F 677	<p><i>NJ Ex Order 26. 4B1</i></p> <p>Resident #65, Resident #29, Resident #63, and residents in rooms <i>NJ Ex Order 26. 4B1</i>, were monitored for any adverse effects with none noted.</p> <p>All residents were monitored for <i>NJ Ex Order 26. 4B1</i> with <i>NJ Ex Order 26. 4B1</i>.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the Director of Nursing/Designee initiated reeducation for staff on the facility's "Call Lights: Accessibility and Timely Response" policy.</p> <p>On 4/15/2025, the Director of Nursing/Designee initiated reeducation for Certified Nursing Assistants, Licensed Practical Nurses, and Registered Nurses on the following policies: Incontinence, Activities of Daily Living (ADLs), and Nursing Services and Sufficient Staff.</p> <p>Measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>The Director of Nursing/Designee will conduct audits to ensure residents who require assistance with their daily</p>		

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F 677	<p>Continued From page 11</p> <p><i>NJ Ex Order 26. 4B1</i> [redacted] CNA #1 further stated that it was importance to [redacted] resident every two hours to prevent [redacted].</p> <p>On 3/26/25 at 11:20 AM, the surveyor interviewed the <i>U.S. FOIA (b) (6)</i> [redacted], who stated that the schedule to <i>NJ Ex Order 26. 4B1</i> [redacted] was specific to each resident and their needs. The <i>U.S. FOIA (b) (6)</i> [redacted] also stated that they do not have specific time frames to [redacted] the resident's <i>NJ Ex Order 26. 4B1</i>.</p> <p>On 3/27/25 at 10:14 AM, the <i>U.S. FOIA (b) (6)</i> [redacted], in the presence of the <i>U.S. FOIA (b) (6)</i> [redacted], and the survey team, acknowledged that CNAs needed to ensure timely <i>NJ Ex Order 26. 4B1</i> [redacted] were being completed.</p> <p>2. On 3/23/25 at 10:34 AM, the surveyor observed the call device for Resident Room [redacted] on at 10:34 AM. The nurse call device system at the nurse's station revealed it was activated for three minutes at 10:34 AM. The surveyor observed LPN/UM #1 enter the room at 10:41 AM. The nurse call device system present at the nurse's station revealed that Resident Room [redacted] call device was activated for ten minutes when attended to at 10:41 AM.</p> <p>On 3/24/25 at 9:13 AM, the surveyor observed the call device for Resident Room [redacted] on at 9:13 AM. The nurse call device system at the nurse's station revealed that the call device at 9:19 AM, had been activated for fourteen minutes at that time. During the surveyor observation, it was</p>	F 677	<p>activities of living (ADLs) receive incontinence care and staff answer resident call systems to provide care and services as required. The Director of Nursing/Designee will conduct one weekly audit of three residents to ensure that they receive proper incontinence care and one weekly audit of three resident rooms to ensure that staff answered resident call systems as required for four weeks, then two audits monthly for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting</p>		

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

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F 677	<p>Continued From page 12</p> <p>observed that multiple staff walked past the resident's room during the call device being activated. At 9:22 AM, the surveyor observed a staff member enter the room to assist the resident and turned the call device off. The call device was activated for seventeen minutes.</p> <p>On 3/24/25 at 9:29 AM, the surveyor observed the call device for Resident Room ^{NJ Ex Order} was triggered on at 9:29 AM. The surveyor observed two staff walk by the resident's room on three occasions. At 9:40 AM, the surveyor observed a staff member enter the room to assist the resident and turned off the call device.</p> <p>On 3/27/25 at 10:14 AM, the ^{U.S. FOIA (b)(6)} in the presence of the <u>U.S. FOIA (b) (6)</u>, and the survey team, stated that call device response times were very serious. The ^{U.S. FOIA (b)(6)} further stated that weekly audits for call devices have been completed and the longest weight time was ten minutes. The ^{U.S. FOIA (b)(6)} further stated that no staff should walk by a call device light without seeing the need of the resident.</p> <p>A review of the facility's "Call Lights: Accessibility and Timely Response" policy with an implemented date of 9/1/24, included...The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow resident to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response ...10. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. 11. Process for responding to call lights:</p>	F 677			

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F 677	<p>Continued From page 13</p> <p>a. turn off the signal light in the resident's room ...c. listen to the resident's request and respond accordingly. Inform the resident if you cannot meet the need and assure him/her that you will notify the appropriate personnel. d. inform the appropriate personnel of the resident's need...</p> <p>3. On 3/24/25 at 9:10 AM, the surveyor conducted with LPN/UM #1 an NJ Ex Order 26. 4B1 and observed the following:</p> <p>On 3/24/25 at 9:23 AM, the surveyor and LPN/UM #1 observed Resident #63 in bed. LPN/UM #1 NJ Ex Order 26. 4B1 the resident's NJ Ex Order 26. 4B1. The surveyor observed the NJ Ex Order 26. 4B1 was NJ Ex Order 26. 4B1. There was also NJ Ex Order 26. 4B1. NJ Ex Order 26. 4B1 that LPN/UM #1 acknowledged was a NJ Ex Order 26. 4B1. LPN/UM #1 stated that the resident NJ Ex Order 26. 4B1.</p> <p>On 3/24/25 at 9:27 AM, the surveyor and LPN/UM #1 observed Resident #29 in bed. LPN/UM #1 exposed the resident's NJ Ex Order 26. 4B1. The surveyor observed the NJ Ex Order 26. 4B1 to be NJ Ex Order 26. 4B1. There was also large amount of formed NJ Ex Order 26. 4B1 that the U.S. FOIA (b) (6) acknowledged was a NJ Ex Order 26. 4B1. The surveyor observed the NJ Ex Order 26. 4B1 around the resident's NJ Ex Order 26. 4B1. The resident stated that nobody NJ Ex Order 26. 4B1. LPN/UM #1 stated that the resident would be NJ Ex Order 26. 4B1.</p> <p>On 3/26/25 at 10:38 AM, the surveyor interviewed CNA #2, who stated that they NJ Ex Order 26. 4B1 the residents' NJ Ex Order 26. 4B1 or</p>	F 677			

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F 677	<p>Continued From page 14</p> <p>as needed because the residents could develop NJ Ex Order 26. 4B1 if they were not NJ Ex Order 26. 4B1 when they needed to. CNA #2 also stated that as soon as they started their shift at 7:00 AM, the CNAs did rounds with the CNAs from the 11:00 PM to 7:00 AM (night) shift and received reports. CNA #2 confirmed that the 7:00 AM to 3:00 PM (day) shift CNAs do the morning rounds and that the night shift CNAs did their last rounds at 5:00 AM.</p> <p>On 3/26/25 at 10:40 AM, the surveyor interviewed CNA #3, who stated that they checked the residents' NJ Ex Order 26. 4B1 or more depending on how often the resident NJ Ex Order 26. 4B1.</p> <p>On 3/26/25 at 10:42 AM, the surveyor interviewed CNA #1, who stated that they checked the residents every two hours.</p> <p>A review of the facility's NJ Ex Order 26. 4B1 policy with an implemented date of 9/1/24, included ...based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services...4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible...</p> <p>A review of the facility's "Activities of Daily Living (ADLs)" policy with an implemented date of 9/1/24, included...Care and services will be provided for the following activities of daily living:...3. Toileting ...Policy Explanation and Compliance Guidelines:...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good</p>	F 677			

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F 677	Continued From page 15 nutrition, grooming, and personal and oral hygiene... A review of the facility's "Nursing Services and Sufficient Staff" policy dated implemented on 3/3/25, included...1. The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans...	F 677			
F 686 SS=D	NJAC 8:39-27.1(a) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) maintain infection control to reduce the risk of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines	F 686	Residents affected by deficient practice: The facility failed to a.) maintain infection control to reduce the risk of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines	5/21/25	

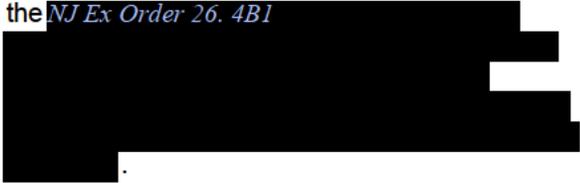
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F 686	<p>Continued From page 16</p> <p>and standards of clinical practice during a ^{NJ Ex Order 26. 4B1} and b.) ensure a treatment was administered in accordance with a physician order. This deficient practice was identified for ^{NJ Ex Order 26. 4B1}:</p> <p>Reference: CDC Recommendations for Hand Hygiene, updated 2/27/24, Hand hygiene should be performed immediately before touching a patient; before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; before moving from work on a soiled body site to a clean body site on the same patient; after touching a patient or patient's surroundings; after contact with blood, body fluids, or contaminated surfaces; immediately after glove removal. https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html#cdc_clinical_safety_best_practices_recomm-recommendations</p> <p>On 3/23/25 at 10:34 AM, the surveyor observed Resident #46 lying in bed on an ^{NJ Ex Order 26. 4B1}. The ^{U.S. FOIA (b) (6)} on duty stated that the resident had a ^{NJ Ex Order 26. 4B1}.</p> <p>On 3/24/25 at 12:31 PM, the surveyor observed the ^{U.S. FOIA (b) (6)} perform the ^{NJ Ex Order 26. 4B1} for the resident's ^{NJ Ex Order 26. 4B1} assisted by the ^{U.S. FOIA (b) (6)} (CNA #1) and observed the following:</p> <p>During the ^{NJ Ex Order 26. 4B1} observation, the surveyor observed the ^{U.S. FOIA (b) (6)} and CNA #1 wearing surgical masks, gowns, and gloves. The ^{U.S. FOIA (b) (6)} gown was observed untied on the top part. The resident</p>	F 686	<p>and standards of clinical practice during a ^{NJ Ex Order 26. 4B1} and b.) ensure a treatment was administered in accordance with a physician order. This deficient practice was ^{NJ Ex Order 26. 4B1}</p> <p>Resident # 46 was monitored for any ^{NJ Exec Order 26.4b1}</p> <p>All residents were monitored for adverse effects with none noted.</p> <p>^{U.S. FOIA (b) (6)} was re-educated by the Director of Nursing on 3/24/2025 on proper Personal Protective Equipment policy and Wound Treatment Management Policy.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the Director of Nursing/Designee initiated reeducation for Licensed Nursing Staff on the facility's Wound Treatment Management" policy.</p> <p>On 4/15/2025, the Director of Nursing/Designee initiated reeducation for staff on the facility's "Personal Protective Equipment" policy.</p>		

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F 686	<p>Continued From page 17</p> <p>was ^{NJ Exec Order 26.4b1} on their ^{NJ Exec Order 26.4b1} of the ^{NJ Ex Order 26.4B1}</p> <p>^{U.S. FOIA}. While the ^{U.S. FOIA} was cleansing the resident's ^{NJ Ex Order 26.4B1}, the nurse's loose gown sleeve touch the ^{NJ Ex Order 26.4B1}. Then the LPN dropped the ^{NJ Ex Order 26.4b1} she was cleaning with onto the ^{NJ Ex Order 26.4B1}, picked it up, and proceeded to use that ^{NJ Ex Order 26.4B1} to clean around the ^{NJ Ex Order 26.4B1}.</p> <p>Then the ^{U.S. FOIA} without changing her gloves or performing hand hygiene, removed a tube of ^{NJ Ex Order 26.4B1} from the treatment cart in the hallway, squeezed the cream onto her right hand, and applied it to the ^{NJ Ex Order 26.4B1}. The ^{U.S. FOIA} then changed her gloves and performed hand hygiene, and then used her gloved hands to remove a ^{NJ Ex Order 26.4B1} from the treatment cart. The ^{U.S. FOIA} then with the same gloved hands opened a package of ^{NJ Ex Order 26.4B1} and applied the powder directly to the ^{NJ Ex Order 26.4B1} and the edges of the packet were observed touching the ^{NJ Ex Order 26.4B1}.</p> <p>Without changing gloves and performing hand hygiene, the ^{U.S. FOIA} took an unlabeled ^{NJ Ex Order 26.4B1}.</p> <p>The ^{U.S. FOIA} used the same ^{NJ Exec Order 26.4b1} that was ^{NJ Ex Order 26.4B1} from touching the ^{NJ Ex Order 26.4B1} to the applicator. The ^{NJ Ex Order 26.4B1} of the applicator touched the ^{NJ Ex Order 26.4B1}.</p> <p>The ^{U.S. FOIA} then took a new ^{NJ Exec Order 26.4b1} and ^{NJ Ex Order 26.4B1}, and the ^{U.S. FOIA} tried to apply the ^{NJ Exec Order 26.4b1} inside the ^{NJ Ex Order 26.4B1}.</p>	F 686	<p>Measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>The Director of Nursing/Designee will conduct audits to ensure residents receive wound treatment properly and as required and that staff utilize Personal Protective Equipment properly. The Director of Nursing/Designee will conduct one weekly audit of three residents who require wound treatment to ensure that they receive proper treatment as ordered by the physician and one weekly audit of three staff members to ensure utilization of Personal Protective Equipment as required for four weeks, then two audits monthly for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting</p>	

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F 686	<p>Continued From page 18</p> <p>using their left hand and the [NJ Exec Order 26.4B1] Parts of the [NJ Exec Order 26.4B1] were observed touching the [NJ Ex Order 26.4B1] the resident was lying down on. The [U.S. FOIA] picked up the parts of the [NJ Exec Order 26.4B1] that touched the [NJ Ex Order 26.4B1] with the applicator. After a bundle of strips fell to the [NJ Ex Order 26.4B1], the [U.S. FOIA] picked up those [NJ Exec Order 26.4B1] with her left gloved hand and placed the [NJ Exec Order 26.4B1] inside of the [NJ Ex Order 26.4B1] with her gloved hand.</p> <p>Without changing gloves or performing hand hygiene, the [U.S. FOIA] covered the packed [NJ Ex Order 26.4B1].</p> <p>The resident was then turned to their back with the [NJ Ex Order 26.4B1] underneath them and on top of the [NJ Ex Order 26.4B1]. The [U.S. FOIA] then removed her gloves, but did not perform hand hygiene. The [U.S. FOIA] took a sanitizing wipe from the treatment cart and wiped down the scissors, [NJ Ex Order 26.4B1] with the same wipe. The [U.S. FOIA] then cleaned the overbed table with the same sanitizing wipe used to clean the [NJ Ex Order 26.4B1] and scissors. The [U.S. FOIA] discarded the sanitizing wipe, treatment table liner, gown, and gloves, and proceeded to wash hands. The [U.S. FOIA] returned the unlabeled [NJ Ex Order 26.4B1] to first drawer of the treatment cart.</p> <p>After [NJ Ex Order 26.4B1] was completed, the resident was turned to their right side and the [NJ Ex Order 26.4B1] was rolled beneath them and thrown on the trash can by CNA #1. CNA #1 removed their gloves and washed their hands appropriately. CNA #1 put on a new pair of gloves and applied a new [NJ Ex Order 26.4B1] used earlier for [NJ Ex Order 26.4B1].</p>	F 686			

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F 686	<p>Continued From page 19</p> <p>On 3/24/25 at 1:05 PM, the surveyor discussed their observed concerns from the ^{NJ Ex Order 26. 4B1} with the ^{NJ Ex Order}. The ^{U.S. FOIA (b) (6)} stated that they should have changed gloves and performed hand hygiene between clean and unclean procedures. The ^{U.S. FOIA (b) (6)} stated that they instructed CNA #1 to remove the ^{NJ Ex Order 26. 4B1} brief prior to the treatment, but the ^{U.S. FOIA (b) (6)} did not remove it. The ^{U.S. FOIA (b) (6)} stated that they tried not to touch the tip of the ^{NJ Ex Order 26. 4B1}, and she should have disposed it and used a new one. The ^{U.S. FOIA (b) (6)} stated that she would label the ^{NJ Ex Order 26. 4B1} and proceeded to write resident's name on the ^{NJ Ex Order 26. 4B1} and returned it to the cart. The ^{U.S. FOIA (b) (6)} stated that ^{NJ Ex Order 26. 4B1} should have been used to cleanse the area around the ^{NJ Ex Order 26. 4B1} to the application of other treatments as ordered. The ^{U.S. FOIA (b) (6)} stated to the surveyor that they ^{NJ Ex Order 26. 4B1}."</p> <p>On 3/24/25 at 1:09 PM, the surveyor discussed the ^{NJ Ex Order 26. 4B1} observation concerns with the ^{U.S. FOIA (b) (6)} who acknowledged that there were several lapses in terms of infection control that warranted the treatment to be redone. The ^{U.S. FOIA (b) (6)} stated that the ^{NJ Ex Order 26. 4B1} should have been disposed prior to the treatment to avoid cross contamination. The ^{U.S. FOIA (b) (6)} also stated that gloves should have been changed between clean and unclean procedures and that hand hygiene should have been performed before and after changing the gloves. The ^{U.S. FOIA (b) (6)} stated that ^{NJ Ex Order 26. 4B1} should have been applied after cleansing with ^{NJ Exec Order 26.4b1}.</p> <p>On 3/24/25 at 1:30 PM, the surveyor reviewed the</p>	F 686		

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F 686	<p>Continued From page 20 medical record for Resident #46.</p> <p>A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; <i>NJ Ex Order 26. 4B1</i> [REDACTED]</p> <p>A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated <i>NJ Exec Order 26.4b</i>, revealed that the resident had a <i>NJ Ex Order 26. 4B1</i> and that the resident received <i>NJ Ex Order 26. 4B1</i>.</p> <p>A review of the Order Summary Report dated active as of <i>NJ Exec Order 26.4b</i>, included a physician's order to cleanse the area of the <i>NJ Ex Order 26. 4B1</i> [REDACTED]</p> <p>A review of the <i>NJ Exec Order 26.4b1</i> Treatment Administration Record (TAR) reflected that the ordered treatment was administered by the <i>U.S. FOMI</i> on the day shift of <i>NJ Exec Order 26.1</i>.</p> <p>A review of the comprehensive individual care plan (ICCP) dated revised on <i>NJ Exec Order 26.4b</i>, included a focus for <i>NJ Ex Order 26. 4B1</i> [REDACTED] with the goal for the resident not to have symptoms of infection. Interventions include that the <i>NJ Ex Order 26. 4B1</i> recommended to continue treatment as ordered; or <i>NJ Exec Order 26.1</i>, the <i>NJ Ex Order 26. 4B1</i> recommended to <i>NJ Exec Order 26.4</i></p>	F 686			

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F 686	Continued From page 21 the <i>NJ Ex Order 26. 4B1</i>  During an interview with the surveyor on 3/26/25 at 12:37 PM, the <i>U.S. FOIA (b) (6)</i> stated that hand hygiene should be performed before and after gloves changes and gloves should be changed between clean and unclean procedures to prevent cross contamination and infection. A review of facility's <i>NJ Ex Order 26. 4B1</i> Treatment Management" policy dated 9/1/24, included Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders... A review of facility's "Personal Protective Equipment" policy dated 9/1/24, included Policy Explanation and Compliance Guidelines:...4.a.iv. Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn;...4.b.ii. Gowns should fully cover torso from neck to knees, arms to end of wrist, and wrap around the back. Fasten in back at neck and waist...	F 686			
F 698 SS=D	NJAC 8:39 - 27.1(a)(e) Dialysis CFR(s): 483.25(l)	F 698			5/21/25

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F 698	<p>Continued From page 22</p> <p>§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure ^{NJ Ex Order 26. 4B1} communication forms between the facility and the contracted ^{NJ Ex Order 26. 4B1} were consistently completed. This deficient practice was identified for ^{NJ Ex Order 26. 4B1}.</p> <p>1. On 3/23/25 at 10:32 AM, during initial tour of the facility, the surveyor observed Resident #45 seated in their wheelchair in the hallway. Resident #45 stated that they go to ^{NJ Ex Order 26. 4B1}.</p> <p>On 3/24/25 at 12:52 PM, the surveyor reviewed the medical record for Resident #45.</p> <p>A review of the Transfer/Discharge Report face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but were not limited to; ^{NJ Ex Order 26. 4B1}.</p>	F 698	<p>Residents affected by deficient practice:</p> <p>The facility failed to ensure ^{NJ Ex Order 26. 4B1} communication forms between the facility and the contracted ^{NJ Ex Order 26. 4B1} facility were consistently completed. This deficient practice was identified for ^{NJ Ex Order 26. 4B1}.</p> <p>Resident # 25 was monitored for any ^{NJ Exec Order 26.4b1}.</p> <p>Resident # 45 no longer resides in the facility.</p> <p>An audit was completed by the Director of Nursing for all residents who receive Hemodialysis to ensure that proper communication with the contracted dialysis facility was consistently completed.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents who receive hemodialysis have the potential to be affected.</p> <p>What corrective action will be</p>		

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F 698	<p>Continued From page 23</p> <p>A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted] reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated a [redacted] <i>NJ Ex Order 26. 4B1</i>. A further review included the resident received [redacted] while at the facility.</p> <p>A review of the Order Summary Report included a physician's order (PO) dated [redacted], for [redacted]; seating time 6:00 AM.</p> <p>A review of the individualized comprehensive care plan (ICCP) included a focus area dated [redacted], that the resident needed [redacted] <i>NJ Ex Order 26. 4B1</i>. Interventions included but were not limited to; [redacted] <i>NJ Ex Order 26. 4B1</i> [redacted], monitor [redacted] and report to the doctor as needed, and do not [redacted] <i>NJ Ex Order 26. 4B1</i>.</p> <p>On 3/24/25 at 12:52 PM, the surveyor reviewed Resident #45's [redacted] <i>NJ Ex Order 26. 4B1</i> communication record that was sent with the resident on [redacted] <i>NJ Ex Order 26. 4B1</i> days. The communication forms were reviewed for [redacted] <i>NJ Ex Order 26. 4B1</i> and [redacted] <i>NJ Ex Order 26. 4B1</i>. The following [redacted] <i>NJ Ex Order 26. 4B1</i> communication forms were not completed by the facility's nurse upon return from [redacted] <i>NJ Ex Order 26. 4B1</i>.</p> <p>On 3/25/25 at 10:35 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who stated the [redacted] <i>NJ Ex Order 26. 4B1</i> communication form was completed by the nurse prior to departure and it was sent to [redacted] <i>NJ Ex Order 26. 4B1</i> with the resident. LPN #1</p>	F 698	<p>accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the Director of Nursing/Designee initiated reeducation for Licensed Nursing Staff on facility's "Hemodialysis" policy.</p> <p>Measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>The Director of Nursing/Designee will conduct audits to ensure that proper communication with the contracted dialysis facility was consistently completed for residents who receive hemodialysis. The Director of Nursing/Designee will conduct one weekly audit of all residents who receive Hemodialysis for four weeks, then two audits monthly for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting</p>		

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F 698	<p>Continued From page 24</p> <p>also stated that when the resident returned from [redacted], the nurse obtained vital signs, checked the [redacted], reviewed the [redacted] communication form and signed the bottom of the form indicating the nurse reviewed it. LPN #1 further stated the nurse reviewed the information from the [redacted] for medication changes, new orders, and the resident's [redacted] LPN #1 stated the purpose of the [redacted] communication form was to have communication between the facility and the [redacted]. LPN #1 acknowledged that the [redacted] communication forms should not have any blank sections, and the nurse should sign it upon the resident's return.</p> <p>On 3/25/25 at 11:23 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1), who stated when the resident was sent out to [redacted], their communication book went with them. LPN/UM #1 also stated that the [redacted] was responsible to review and sign the [redacted] communication form when the resident returned from [redacted]. LPN/UM #1 further stated that the purpose of the [redacted] communication form was to see if there were any changes with the resident's medication, [redacted] and vital signs. LPN/UM #1 acknowledged that the [redacted] communication forms should not have blanks and that the [redacted] should have signed the form upon return.</p> <p>On 3/26/25 at 11:20 AM, the surveyor interviewed the [redacted], who stated the purpose of the [redacted] communication form was to ensure proper coordination of care for the resident. The [redacted] further stated that when a resident went out to [redacted], the nurse was responsible to complete the [redacted]</p>	F 698			

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F 698	<p>Continued From page 25</p> <p>NJ Ex Order 26. 4B1" section with vital signs, and upon the resident's return, the nurse reviewed the form and signed the bottom of the form. The U.S. FOIA (b) (6) also stated if there were any new orders the U.S. FOIA (b) (6) followed up with the U.S. FOIA (b) (6). The U.S. FOIA (b) (6) acknowledged that the NJ Ex Order 26. 4B1 communication forms were not filled out completely on the following dates: NJ Ex Order 26. 4B1</p> <p>On 3/27/25 at 10:14 AM, the U.S. FOIA (b) (6), in the presence of the U.S. FOIA (b) (6), and the survey team, stated NJ Ex Order 26. 4B1 communication forms should be reviewed and signed by the NJ Ex Order 26. 4B1 upon the resident's return from NJ Ex Order 26. 4B1. The U.S. FOIA (b) (6) acknowledged that the NJ Ex Order 26. 4B1 communication forms were not filled out completely.</p> <p>2. A review of the facility Admission Record face sheet for Resident #25 reflected that the resident was admitted to the facility with the diagnoses that included but were not limited to; NJ Ex Order 26. 4B1.</p> <p>A review of the comprehensive MDS dated NJ Ex Order 26. 4B1, reflected that Resident #25 was NJ Ex Order 26. 4B1. The MDS also reflected that the resident received NJ Ex Order 26. 4B1.</p> <p>On 3/23/25 at 10:54 AM, during initial facility tour, the surveyor observed Resident #25 lying in bed.</p>	F 698		

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F 698	<p>Continued From page 26</p> <p>The resident was [redacted] and stated that they had a [redacted] NJ Ex Order 26. 4B1 [redacted]. The resident explained that they went out for [redacted] NJ Ex Order 26. 4B1 [redacted]. The surveyor observed a [redacted] NJ Ex Order 26. 4B1 [redacted] to the resident's [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>A review of the physician's order summary reflected a physician's order dated [redacted] NJ Ex Order 26. 4B1 [redacted], for the resident to go out for [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>A review of the ICCP reflected that the resident required [redacted] NJ Ex Order 26. 4B1 [redacted] with interventions that included: to monitor/document/report and signs or symptoms of infection to [redacted] NJ Ex Order 26. 4B1 [redacted], monitor [redacted] NJ Ex Order 26. 4B1 [redacted] and report to doctor as needed and that the resident received [redacted] NJ Ex Order 26. 4B1 [redacted].</p> <p>On 3/24/25 at 11:43 AM, the surveyor attempted to review the resident [redacted] NJ Ex Order 26. 4B1 [redacted]. LPN/UM #2 was not able to locate the [redacted] NJ Ex Order 26. 4B1 [redacted] communication book. The surveyor interviewed the resident at that time, who stated that they usually took paperwork to the [redacted] NJ Ex Order 26. 4B1 [redacted] for them to fill out and then the communication sheet went back to the nurses. The resident stated, "[redacted] NJ Ex Order 26. 4B1 [redacted]."</p> <p>On 2/24/25 at 12:00 PM, the surveyor interviewed the facility's [redacted] U.S. FOIA (b) (6) [redacted], who was also not able to locate the [redacted] NJ Ex Order 26. 4B1 [redacted] communication book and was only able to provide two [redacted] NJ Ex Order 26. 4B1 [redacted] communication sheets since</p>	F 698			

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

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F 698	Continued From page 27 NJ Exec Order 26.4B1, dated NJ Ex Order 26.4B1. On 3/27/25 at 10:14 AM, the surveyor interviewed the U.S. FOIA (b), who stated that the NJ Ex Order 26.4B1 communication forms were an important form that was utilized as a form of communication between the NJ Ex Order 26.4B1 and the facility. The U.S. FOIA (b) stated that the forms were an important part of the resident's clinical record and included vital signs, NJ Exec Order 26.4B1 and any procedures that were performed at the NJ Ex Order 26.4B1. The U.S. FOIA (b) stated that the nurse should assure that the forms in the NJ Ex Order 26.4B1 book were kept as part of the resident's medical record. A review of the facility's "NJ Ex Order 26.4B1" policy dated 9/1/24, included 5. the licensed nurse will communicate to the dialysis facility via telephone communication or written format, such as a dialysis communication form or other form...	F 698			
F 755 SS=D	NJAC 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		5/21/25	

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F 755	<p>Continued From page 28</p> <p>dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent records, it was determined that the facility failed to a.) ensure the accountability of the narcotic shift count logs were completed and b.) accurately account for and document the administration of NJ Exec Order 26.4b1. This deficient practice was identified on 2 of 3 medication carts (NJ Exec Order 26.4b1 #NJ and #NJ reviewed and was evidenced by the following:</p> <p>On 3/25/25 at 10:20 AM, the surveyor, accompanied by the U.S. FOIA (b) (6), reviewed the NJ Ex Order 26.4B1 nursing unit's medication cart #1. The following was observed when the NJ Exec Order 26.4b1 logbook was reviewed:</p> <p>The nurse's signature for the going off duty was missing on: NJ Ex Order 26.4b1 the 3:00 PM to 11:00 PM</p>	F 755	<p>Residents affected by deficient practice:</p> <p>The facility failed to a.) ensure the accountability of the narcotic shift count logs were completed and b.) accurately account for and document the administration of controlled medications. This deficient practice was identified on NJ</p> <p>Residents #3, #17, #33, #42, #46, and #397 were assessed with NJ Exec Order 26.4b1</p> <p>An audit was completed by the Director of Nursing on 3/25/2025 for all narcotic shift count logs on all medication carts and no</p>		

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F 755	<p>Continued From page 29</p> <p>(evening) shift; ^{NJ Ex Order 26.4B1} the 7:00 AM to 3:00 PM (day) shift; and ^{NJ Ex Order 26.4B1} the evening shift.</p> <p>The nurse's signature for the coming on duty was missing on the ^{NJ Ex Order 26.4B1} night shift.</p> <p>A further review of the declining inventory logs indicated that Resident #56 should have had ^{NJ Ex Order 26.4B1} ^{NJ Ex Order 26.4B1}, but only ^{NJ Ex Order 26.4B1} were on hand. The ^{U.S. FOIA (b) (6)} at that time, stated she administered the medication during the morning medication pass and failed to sign it out. The ^{U.S. FOIA (b) (6)} further stated that controlled medications should be signed out immediately for each dose administered so that the ^{NJ Exec Order 26.4B1} were accounted for.</p> <p>On 3/25/25 at 11:35 AM, the surveyor, accompanied by the ^{U.S. FOIA (b) (6)}, reviewed the ^{NJ Ex Order 26.4B1} nursing unit's medication cart # ^{NJ Ex Order 26.4B1}. The following was observed when the ^{NJ Exec Order 26.4B1} logbook was reviewed:</p> <p>The nurse's signature for the incoming and outgoing nurse was blank for the ^{NJ Ex Order 26.4B1} evening shift.</p> <p>A further review of the declining inventory logs indicated the following ^{NJ Exec Order 26.4B1} doses that were administered and not signed out when compared to their corresponding Medication Administration Records (MAR):</p> <p>Resident #3: ^{NJ Ex Order 26.4B1}</p>	F 755	<p>concerns were found.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the Director of Nursing/Designee initiated reeducation for Licensed Nursing Staff on facility's "Controlled Substance Administration and Accountability" policy and ensure the narcotic shift count logs were completed properly and accurately account for and document the administration of controlled medications.</p> <p>Measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>The Director of Nursing/Designee will conduct audits to ensure compliance with the Controlled Substance Administration and Accountability policy. The Director of Nursing/Designee will conduct one weekly audit of all medication carts and narcotic shift count logs for four weeks, then two audits monthly for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued</p>	

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F 755	<p>Continued From page 30</p> <p><i>NJ Ex Order 26. 4B1</i></p> <p>Resident #42: <i>NJ Ex Order 26. 4B1</i></p> <p>Resident #46: <i>NJ Ex Order 26. 4B1</i></p> <p>Resident #397: <i>NJ Ex Order 26. 4B1</i></p> <p>At that time, the ^{U.S. FOIA} stated to the surveyor that the narcotic shift-to-shift accountability logs should not have any missing signatures and that the declining inventory logs should have been updated for each dose administered at the time of administration. The ^{U.S. FOIA} stated the reason was to maintain ^{NJ Exec Order 26.4B1} accountability, but ^{NJ Ex Order 26. 4B1}</p> <p>"</p> <p>On 3/25/25 at 12:15 PM, the surveyor interviewed the ^{U.S. FOIA (b) (6)}, who stated that the expectation was that the shift-to-shift logs were completed and signed by the incoming nurse and outgoing nurse at the time of medication cart hand off, whether it be at shift change or otherwise. The ^{U.S. FOIA (b) (6)} stated that the requirement was that two licensed nurses completed the ^{NJ Exec Order 26.4B1} count together and signed the log which indicated that the count was completed and accurate. The ^{U.S. FOIA (b) (6)} stated that there should never be any missing signatures. The ^{U.S. FOIA (b) (6)} further stated that the declining inventory logs were used to keep accountability of ^{NJ Exec Order 26.4B1} administered and that each sheet should be filled out for each dose administered in real time, and that nurses were not to wait to sign out the dose later.</p> <p>A review of the facility's "Controlled Substance Administration and Accountability" policy with a</p>	F 755	submission and reporting.	

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F 755	Continued From page 31 revised date of 3/17/25, included in all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the medication administration record (MAR), controlled drug record, or other facility specified form and placed in the patient's medical record...nursing staff (2) must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services...	F 755			
F 761 SS=D	NJAC 8:39-29.7(c) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		5/21/25	

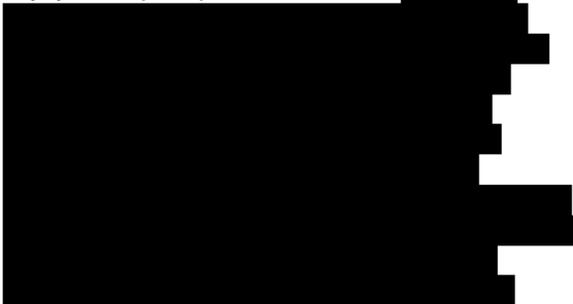
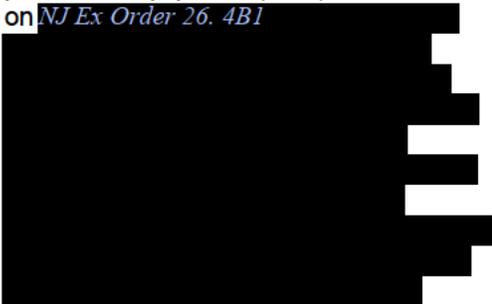
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F 761	<p>Continued From page 32</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of facility policy, it was determined that the facility failed to properly store and secure medications. This deficient practice was observed in 1 of 3 medication carts reviewed [NJ Exec Order 26.4B1] [NJ Ex] and was evidenced as follows:</p> <p>On 3/25/25 at 11:35 AM, the surveyor observed the [NJ Ex Order 26.4B1] nursing unit's medication cart # [NJ Ex]. The medication cart was next to the nurse's station and was unattended by any nursing staff. The cart was observed to be unlocked and had a bottle of [NJ Ex Order 26.4B1] left unattended on top of the cart. At that time, the surveyor requested that the nurse assigned to the cart to be paged to come to the cart. The [U.S. FOIA (b) (6)] assigned to the cart came out of a resident's room down the hall and approached the surveyor at the cart. The surveyor interviewed the [U.S. FOIA] who stated that medication should not have been left unattended and unsecured. The [U.S. FOIA] also confirmed that the medication cart should have been secured since it was left unattended. The [U.S. FOIA] further stated that she had [NJ Ex Order 26.4B1]."</p> <p>The surveyor did not observe any residents ambulating independently near the medication cart.</p> <p>On 3/25/25 at 12:15 PM, the surveyor interviewed</p>	F 761	<p>Residents affected by deficient practice:</p> <p>The facility failed to properly store and secure medications. This deficient practice was observed in [NJ Ex Order 26.4B1].</p> <p>The bottle of [NJ Ex Order 26.4B1] was removed and stored properly upon notification.</p> <p>The [U.S. FOIA] was reeducated by the Director of Nursing on the facility's "Medication Storage" policy on 3/25/2025.</p> <p>No residents were identified or affected.</p> <p>The facility's Nursing Leadership Team conducted an audit on 3/25/2025 of all medication carts to ensure that all medications were properly stored and secured and that all medication carts were locked as required when not attended.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected</p>		

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F 761	Continued From page 33 the <u>U.S. FOIA (b) (6)</u> , who stated medications and medication carts should never be left unsecured and medications should not have been left on top of the medication cart when unattended. The <u>U.S. FOIA (b) (6)</u> stated medications should only be accessible to licensed nurses to ensure that residents and others cannot access medications. A review of the facility's "Medication Storage" policy with an implemented date of 9/1/24, included all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Only authorized personnel will have access to the keys to locked compartments. During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart... NJAC 8:39-29.4(h)	F 761	by the deficient practice: On 4/15/2025, the Director of Nursing/Designee initiated reeducation for all Licensed Nursing Staff on the facility's "Medication Storage" policy. Measures or systemic changes to ensure that the deficiencies will not recur: The Director of Nursing/Designee will conduct audits to ensure compliance with the Medication Storage policy. The Director of Nursing/Designee will conduct one weekly audit of all medication carts for four weeks, then two audits monthly for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		5/21/25	

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F 812	<p>Continued From page 34</p> <p>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.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 3/23/25 at 9:23 AM, during initial tour of the kitchen, the surveyor accompanied by the [U.S. FOIA (b) (6)], and observed the following:</p> <p>An opened container of bulk beef base. The beef base was not labeled with a use by date and contained a coffee mug that was used as a scooper in the beef base.</p> <p>A large, opened container of flour that contained a coffee mug left inside the flour to be used as a scooper.</p> <p>On 3/23/25 at 10:05 AM, the surveyor interviewed the [U.S. FOIA (b) (6)], who stated that the bulk beef base should have had a use by date on the container and the coffee mugs should not be used as scoopers. The [U.S. FOIA (b) (6)] acknowledged that scoopers should not be left in the flour or beef base for infection control</p>	F 812	<p>Residents affected by deficient practice:</p> <p>The facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness.</p> <p>No residents were identified or affected.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>All residents were monitored for any adverse effects with none noted.</p> <p>An audit of the kitchen was completed on 3/23/2025 by the [U.S. FOIA (b) (6)] to ensure that only proper scoopers were in use and that no scoopers were left inside any container. Also, that all dry foods had a use by date.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the Licensed Nursing</p>	

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F 812	Continued From page 35 purposes. On 3/27/25 at 10:13 AM, the U.S. FOIA (b) (6) , in the presence of the survey team, acknowledged that the coffee mugs should not have been used and left in the flour and bulk beef base for infection control purposes. A review of the facility's provided and undated "Dry Food" policy did not include the proper use and storage of scoopers used in the kitchen to scoop out and measure dry ingredients. NJAC 8:39-17.2(g)	F 812	Home Administrator initiated education for dietary staff on the facility's Dry Food policy and that proper scoopers should be always used, and scoopers should not be left inside any container. Also, dry foods to have a use by date. Measures or systemic changes to ensure that the deficiencies will not recur: The Food Service Director/Designee will conduct audits of the kitchen to ensure compliance with Dry Food policy, proper scoopers are always used, scoopers are not left inside any container, and dry foods to have a use by date. The Food Service Director/Designee will conduct one weekly kitchen audit of two dry food items for four weeks, then two audits monthly for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.		
F 880 SS=E	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	F 880		5/21/25	

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F 880	Continued From page 36 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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880			

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F 880	<p>Continued From page 37</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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, record review and other pertinent facility documentation it was determined that the facility failed to use appropriate infection control practices to prevent the spread or reduce the risk of infection by ensuring a.) proper use of personal protective equipment (PPE) for residents on ^{NJ Ex Order 26, 4B1}</p> 	F 880	<p>Residents affected by deficient practice:</p> <p>The facility failed to use appropriate infection control practices to prevent the spread or reduce the risk of infection by ensuring a.) proper use of personal protective equipment (PPE) for residents on ^{NJ Ex Order 26, 4B1}</p> 		

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F 880	<p>Continued From page 38 covering identified for 1 of 2 residents (Resident #17) reviewed for NJ Ex Order 26. 4B1.</p> <p>This deficient practice was evidenced by the following:</p> <p>1. A review of the Admission Record (AR) face sheet (admission summary) indicated that Resident #81 was admitted to the facility with the diagnoses which included but were not limited to; NJ Ex Order 26. 4B1. A review of the Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26. 4B1, reflected that Resident #81 had NJ Ex Order 26. 4B1 and was NJ Ex Order 26. 4B1. The MDS also indicated that the resident had a NJ Ex Order 26. 4B1 and was at risk for development of NJ Ex Order 26. 4B1.</p> <p>On 3/23/25 at 10:57 AM, during initial tour, the surveyor observed a sign on the resident's door which indicated that Resident #81 was NJ Ex Order 26. 4B1. The NJ Ex Order 26. 4B1 indicated that staff were to wear personal protective equipment (PPE) such as an isolation gown and gloves. The surveyor observed PPE in a cart in front of the resident's door that contained gowns and gloves. The surveyor observed a U.S. FOIA (b) (6) (CNA #1) providing direct NJ Ex Order 26. 4B1 wearing only gloves and not an isolation gown.</p> <p>At that time, the U.S. FOIA (b) (6) (LPN/UM #1) walked by the resident's room and was notified by the surveyor the breach in infection control. LPN/UM #1 then entered the</p>	F 880	<p>NJ Ex Order 26. 4B1</p> <p>CNA #1 and CNA #2 were re-educated by the Director of Nursing on 3/23/2025 on proper Personal Protective Equipment use and on the NJ Ex Order 26. 4B1.</p> <p>LPN #1 was re-educated by the Director of Nursing on 3/23/2025 on the requirement to label and date the NJ Ex Order 26. 4B1 used to administer NJ Ex Order 26. 4B1.</p> <p>Resident#81, Resident #397, Resident #64, and Resident #17 were monitored for any NJ Exec Order 26.4b1.</p> <p>All residents were monitored for any adverse effects with none noted.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the Director of Nursing/Designee initiated reeducation for staff on proper Personal Protective</p>		

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F 880	<p>Continued From page 39</p> <p>resident's room. LPN/UM #1 also observed the CNA #1 not wearing the appropriate PPE while performing [redacted] resident care. LPN/UM #1 stated that CNA #1 did not realize the resident was on [redacted] on the door that specified what type of PPE to be applied when providing [redacted] resident care. LPN/UM #1 confirmed that CNA #1 should have been wearing the appropriate PPE such as gown and gloves when [redacted] for Resident #81.</p> <p>A review of the physician's order (PO) dated [redacted] reflected an order to maintain [redacted] related to a history of [redacted].</p> <p>A review of the individual comprehensive care plan (ICCP) dated [redacted] indicated that the resident had actual [redacted] with a goal to [redacted].</p> <p>A review of the facility's "Enhanced Barrier Precautions" policy dated 9/1/24, included that EBP refer to an infection control intervention designed to reduce transmission of multi-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities...initiation of EBP would be obtained for any resident who had wounds or indwelling medical devices...</p> <p>2. During the initial tour of the facility on 3/23/25 at 10:50 AM, the surveyor observed a sign by Resident #397's door which indicated that the resident was on [redacted]. The surveyor observed</p>	F 880	<p>Equipment use and on Enhanced Barrier Precautions policy.</p> <p>On 4/15/2025, the Director of Nursing/Designee initiated reeducation for licensed nursing staff on the requirement to have all nebulizers masks/handheld devices bagged with a date and name of resident.</p> <p>On 4/15/2025, the Director of Nursing/Designee initiated reeducation for licensed nursing staff on the requirement to label and date the piston syringe irrigation kit used to administer tube feeding.</p> <p>Measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>The Director of Nursing/Designee will conduct audits to ensure compliance with Personal Protective Equipment use/Enhanced Barrier Precautions policy, nebulizers masks/handheld devices are bagged with a date and name of the resident, and that piston syringe irrigation kits are labeled and dated. The Director of Nursing/Designee will conduct one weekly audit of two staff members to ensure proper utilization of Personal Protective Equipment, one weekly audit of two residents who receive nebulizer treatment, and one weekly audit of two residents who require the use of a piston syringe irrigation kit for four weeks, then all audits will be two times monthly for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2025
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F 880	<p>Continued From page 40</p> <p>CNA #2 [redacted] Resident #397 in bed. CNA #2 wore gloves with no gown. The surveyor asked CNA #2 what PPE they should be wearing when [redacted] a resident with the [redacted] on the door. CNA #2 stated that they should have worn a gown and gloves.</p> <p>On 3/24/25 at 8:00 AM, the surveyor reviewed the medical record for Resident #397.</p> <p>A review of the AR face sheet indicated the resident was admitted to the facility with diagnoses including but were not limited to; [redacted].</p> <p>A review of the most current quarterly MDS dated [redacted], reflected that the resident did not have any [redacted] but was at risk for developing [redacted].</p> <p>A review of the Order Summary Report dated active as of [redacted], included the following physician's orders (PO):</p> <p>A PO dated [redacted], that the resident required [redacted] status every shift per protocol.</p> <p>A PO dated [redacted], to cleanse [redacted].</p> <p>A review of the ICCP included a focus area revised on [redacted], that the resident required [redacted]. Interventions included to post of signage outside resident's room indicating required PPE and high-contact activities that require the use of PPE.</p>	F 880	<p>Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.</p>		

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F 880	<p>Continued From page 41</p> <p>During an interview with the surveyor on 3/25/25 at 10:01 AM, LPN/UM #2 stated that if a resident was on ^{NJ Ex Order}, staff had to wash their hands, and put on gloves, a gown, and a mask. LPN/UM #2 stated that prior to exiting the room, the staff had to remove the PPE and wash their hands again.</p> <p>During an interview with the surveyor on 3/25/25 at 11:18 AM, the ^{U.S. FOIA (b) (6)} stated that ^{NJ Ex Order} was utilized by staff during high contact activities such as ^{NJ Ex Order 26. 4B1}.</p> <p>3. During the initial tour of the facility on 3/23/25 at 10:17 AM, the surveyor observed Resident #17 sitting in their wheelchair in their room. On top of the resident's side table was a ^{NJ Ex Order 26. 4B1} attached was unlabeled, unbagged, and exposed to air. The ^{NJ Ex Order} connecting the ^{NJ Ex Order 26. 4B1} was observed touching the plastic liner of the trash can in front of the side table.</p> <p>On 3/24/25 at 12:19 PM, the surveyor observed the resident's ^{NJ Ex Order 26. 4B1} on top of the side table with the handheld ^{NJ Ex Order 26. 4B1} unlabeled, unbagged and touching the content of a plastic container.</p> <p>On 3/24/25 at 12:10 PM, the surveyor reviewed the medical record for Resident #17.</p> <p>A review of the AR face sheet indicated the resident was admitted to the facility with</p>	F 880			

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

PRINTED: 07/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2025
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F 880	<p>Continued From page 42</p> <p>diagnoses including but were not limited to; [REDACTED]</p> <p>[REDACTED]</p> <p>A review of the most current quarterly MDS dated [REDACTED] revealed the resident had a [REDACTED]. A further review of the MDS indicated the resident had not received any [REDACTED] look back period.</p> <p>A review of the Order Summary Report dated active as of [REDACTED], included the following physician's order (PO):</p> <p>A PO dated [REDACTED] for [REDACTED]</p> <p>[REDACTED]</p> <p>During an interview with the surveyor on 3/25/25 at 10:01 AM, LPN/UM #2 stated that [REDACTED] should be dated, labeled with the name of the resident, and stored in a plastic bag.</p> <p>During an interview with the surveyor on 3/26/25 at 12:37 PM, the [REDACTED] stated that [REDACTED] should be bagged with date and name of resident.</p> <p>A review of facility's "Oxygen Safety" policy dated implemented on 9/1/24, did not include the care and storage of [REDACTED].</p>	F 880		

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F 880	<p>Continued From page 43</p> <p>4. On 3/23/25 at 10:40 AM, during the initial tour of the facility, the surveyor observed Resident #64 sleeping in their bed. The surveyor observed a <u>NJ Ex Order 26. 4B1</u> in a bag located on the resident's nightstand.</p> <p>On 3/24/25 at 12:07 PM, the surveyor observed LPN #1 administer Resident #64's <u>NJ Ex Order 26. 4B1</u> as per physician orders. The surveyor observed the <u>NJ Ex Order 26. 4B1</u> that LPN #1 used to administer the <u>NJ Ex Order 26. 4B1</u> was not labeled or dated. After LPN #1 completed the administration of the <u>NJ Ex Order 26. 4B1</u>, the surveyor interviewed LPN #1 who stated the <u>NJ Ex Order 26. 4B1</u> were changed daily. LPN #1 stated the <u>NJ Ex Order 26. 4B1</u> should have a date on it to indicate when it was opened. LPN #1 acknowledged that there was no date on the <u>NJ Ex Order 26. 4B1</u> or the container it comes in. LPN #1 then stated it should be dated so we know when it was opened for infection control purposes.</p> <p>On 3/23/25 at 12:58 PM, the surveyor reviewed the medical record for Resident #64.</p> <p>A review of the AR face sheet reflected the resident was admitted to the facility with diagnoses which included but ere not limited to; <u>NJ Ex Order 26. 4B1</u></p> <p>A review of the most recent quarterly MDS <u>NJ Ex Order 26. 4B1</u>, reflected the resident had a Brief Interview for Mental Status (BIMS) score of <u>NJ Ex Order 26. 4B1</u> out of 15, which</p>	F 880			

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F 880	<p>Continued From page 44</p> <p>indicated a NJ Ex Order 26. 4B1. A further review included the resident had a NJ Ex Order 26. 4B1 while at the facility.</p> <p>A review of the Order Summary Report included a physician's order (PO) dated NJ Ex Order 26. 4B1 for NJ Ex Order. A further review revealed a physician's order dated NJ Ex Order 26. 4B1 for NJ Ex Order 26. 4B1.</p> <p>NJ Ex Order 26. 4B1. There was also a physician's order dated NJ Ex Order, to change NJ Ex Order 26. 4B1 every night shift.</p> <p>On 3/25/25 at 10:35 AM, the surveyor interviewed LPN #2, who stated that the NJ Ex Order 26. 4B1 should be changed every day. LPN #2 also stated that the NJ Ex Order 26. 4B1 were labeled with the resident's room number and dated. LPN #2 further stated it was important to label and date the NJ Ex Order 26. 4B1, so the nurse knew when it had been opened and to make sure we were not using old dirty ones.</p> <p>On 3/25/25 at 11:23 AM, the surveyor interviewed LPN/UM #2, who stated the NJ Ex Order 26. 4B1 were changed daily on the NJ Ex Order 26. 4B1 shift. LPN/UM #2 stated that when the NJ Ex Order 26. 4B1 were opened by the nurse, they were to be dated. LPN/UM #2 further stated that the importance of dating the NJ Ex Order 26. 4B1 was to ensure the nurse did not use an old one and for contamination reasons.</p> <p>On 3/26/25 at 11:20 AM, the surveyor interviewed the U.S. FOIA (b), who stated that NJ Ex Order 26. 4B1 were changed daily, every 24 hours, or if needed sooner. The U.S. FOIA (b) stated that the 11: 00</p>	F 880		

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F 880	<p>Continued From page 45</p> <p>PM to 7:00 AM nurse discarded the old [redacted] NJ Ex Order 26. 4B1 and replaced it with a new one. The [redacted] U.S. FOIA (b) also dated that the [redacted] NJ Ex Order 26. 4B1 once it was opened to ensure it was not being used over 24 hours. The [redacted] U.S. FOIA (b) stated that it should not be used over 24 hours due to infection control purposes.</p> <p>On 3/27/25 at 10:14 AM, the [redacted] U.S. FOIA (b), in the presence of the [redacted] U.S. FOIA (b) (6) [redacted], and the survey team, acknowledged that [redacted] NJ Ex Order 26. 4B1 [redacted] should be dated when opened for infection control purposes. The [redacted] U.S. FOIA (b) stated that if a nurse saw an [redacted] NJ Ex Order 26. 4B1 not dated, they were to discard it and get a new one.</p> <p>A review of the facility's "Care and Treatment of Feeding Tubes" policy date implemented 9/1/24 did not address piston syringe irrigation kits.</p> <p>NJAC 8:39-19.1; 19.4(a); 27.1(a)(e)</p>	F 880			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061537	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2025
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S 000	<p>Initial Comments</p> <p>Complaint #: NJ174825, NJ175184, NJ176084, NJ179637, NJ182983, NJ183967, NJ184223</p> <p>The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each 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.</p>	S 000		
S 560	<p>8:39-5.1(a) Mandatory Access to Care</p> <p>The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ175184, NJ179637, NJ182983</p> <p>Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 54 out of 84 shifts reviewed.</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Department of Health</p>	S 560	<p>Residents affected by deficient practice:</p> <p>The facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 54 out of 84 shifts reviewed.</p> <p>No residents were identified.</p> <p>Identify those individuals who could be affected by the deficient practice:</p>	5/21/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/17/25

New Jersey Department of Health

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S 560	<p>Continued From page 1</p> <p>(NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>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</p> <p>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.</p> <p>1. For the week of Complaint staffing from 6/16/24 to 6/22/24, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows:</p> <p>6/16/24 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. 6/17/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. 6/18/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs.</p> <p>2. For the week of Complaint staffing from 1/26/25 to 2/1/25, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as</p>	S 560	<p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>The facility has implemented a competitive market rate for all nursing staff including Certified Nursing Assistants. The facility continues to utilize online recruitment with immediate interviews and contingency offers.</p> <p>On 4/15/2025, the Director of Nursing, Unit Managers, Staffing Coordinator and HR Director were reeducated by the Licensed Nursing Home Administrator on the minimum staffing ratios.</p> <p>The facility implemented an expediated but robust onboarding process.</p> <p>The facility will use agency staff as needed to meet staffing ratios as required.</p> <p>Facility will continue to participate in a bi-weekly recruitment call to review open positions, recruitment tactics, and changes to improve outcomes.</p> <p>Measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>The Licensed Nursing Home Administrator/Designee will conduct audits</p>	
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New Jersey Department of Health

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S 560	<p>Continued From page 2</p> <p>follows:</p> <p>1/26/25 had 9 CNAs for 105 residents on the day shift, required at least 13 CNAs. 1/27/25 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. 1/28/25 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. 1/29/25 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. 1/30/25 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. 1/31/25 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. 2/1/25 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs.</p> <p>3. For the two weeks of staffing prior to survey from 3/9/25 to 3/22/25, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows:</p> <p>3/9/25 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. 3/11/25 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. 3/13/25 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. 3/17/25 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. 3/18/25 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. 3/19/25 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. 3/21/25 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. 3/22/25 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs.</p> <p>On 3/27/25 at 9:14 AM, the surveyor interviewed</p>	S 560	<p>of staffing schedules to ensure compliance with the staffing requirements and minimum staffing ratios. The Licensed Nursing Home Administrator/Designee will conduct one weekly audit of three different shifts for four weeks, then two audits monthly for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.</p>	

New Jersey Department of Health

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S 560	<p>Continued From page 3</p> <p>the Staffing Coordinator (SC), who was able to recite the CNA ratios based on the state regulations. The SC stated that if there were callouts, the facility reached out to agency staff. The SC also stated that bonuses were given to staff who picked up shifts.</p> <p>On 3/27/25 at 9:28 AM, the surveyor interviewed the Director of Nursing (DON), who was able to recite the CNA ratios based on state regulations. The DON stated that when there were callouts, the facility offered staff incentives to cover the shifts. The DON further stated that the facility utilized nursing assistants.</p> <p>A review of the facility's "Nursing Services and Sufficient Staff" policy with an implemented date of 3/3/25, included...1. The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans...</p>	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315333	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 5/22/2025	Y3
NAME OF FACILITY COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 05/21/2025	ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 05/21/2025	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 05/21/2025
ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 05/21/2025	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 05/21/2025	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 05/21/2025
ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 05/21/2025	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 05/21/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/27/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315333	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 5/22/2025	Y3
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NAME OF FACILITY COMPLETE CARE AT ARBORS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757
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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 F0677	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.24(a)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/21/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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FOLLOWUP TO SURVEY COMPLETED ON 3/27/2025	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061537	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/22/2025
NAME OF FACILITY COMPLETE CARE AT ARBORS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757	

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	05/21/2025	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/27/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061537	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 5/22/2025	Y3
NAME OF FACILITY COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/21/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/27/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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

PRINTED: 07/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		
(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	E 000			
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations from 03/24/24 to 03/25/25 and the facility 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.	K 000			
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		5/21/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/17/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 211	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview on 03/24/2025 in the presence of the [REDACTED], it was determined that the facility failed to ensure exits were maintained free of obstructions and impediments for full and instant use in accordance with NFPA 101:2012 Edition, Section 7.1.10.1. for 1 of 2 exits observed. This deficient practice had the potential to affect all 107 residents and was evidenced by the following:</p> <p>An observation at 2:15 PM revealed that the second exit door from the lobby was equipped with a keyed lockset from the egress side The device on the door could restrict emergency use of the exit. The [REDACTED] tested the door by locking and pushed it to open, but they could not.</p> <p>In an interview at the time, the [REDACTED] confirmed the observation.</p> <p>The facility's [REDACTED] were notified of the deficient practice at Life Safety Code survey exit conference on 03/25/2025 at 2:35 PM.</p> <p>N.J.A.C. 8:39-31.2(e)</p>	K 211	<p>Residents affected by deficient practice:</p> <p>The facility failed to ensure exits were maintained free of obstructions and impediments for full and instant use in accordance with NFPA 101:2012 Edition, Section 7.1.10.1. for 1 of 2 exits observed.</p> <p>The keyed lockset from the egress side for the second exit door from the lobby the latch was removed on 3/24/2025 so it could not restrict emergency use of the exit.</p> <p>No residents were affected by this deficient practice.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the [REDACTED] was educated by the Administrator on the requirement for exits to be maintained free of obstructions and impediments for full and instant use.</p> <p>All exits were inspected to ensure that they were maintained free of obstruction and impediments for full and instant use as required.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 211	Continued From page 2	K 211	Measures or systemic changes to ensure that the deficiencies will not recur: The Maintenance Director/Designee will conduct compliance audits to ensure that all exits are maintained free of obstruction and impediments for full and instant use as required. The Maintenance Director/Designee will conduct one weekly audit of all exits for four weeks then two times monthly for two months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.		
K 281 SS=F	<p>Illumination of Means of Egress CFR(s): NFPA 101</p> <p>Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 03/24/2025 in the presence of the ^{U.S. FOIA (b) (6)} [REDACTED], it was determined that the facility failed to provide illumination of the means</p>	K 281	<p>Residents affected by deficient practice:</p> <p>The facility failed to provide illumination of the means of egress that was either continuously in operation or capable of</p>	5/21/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 281	<p>Continued From page 3</p> <p>of egress that was either continuously in operation or capable of automatic operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all 107 residents and was evidence by the following:</p> <p>An observation at 1:27 PM revealed that all the lights in the dining room used as exit access were controlled by a manual light switch on the wall.</p> <p>In an interview at the time, the U.S. FOIA (b) (6) confirmed the observation.</p> <p>The facility's U.S. FOIA (b) (6) were notified of the deficient practice at Life Safety Code survey exit conference on 03/25/2025 at 2:35 PM.</p> <p>N.J.A.C 8:39-31.2(e)</p>	K 281	<p>automatic operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8.</p> <p>No residents were affected by this deficient practice.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the U.S. FOIA (b) (6) was educated by the Administrator on the requirement that illumination of the means of egress are either continuously in operation or capable of automatic operation without manual intervention as required.</p> <p>The light switch on the wall in the dining room was covered with a switch guard on 3/25/2025 to ensure that the lights in the dining room are continuously in operation without manual intervention.</p> <p>All areas of the building were inspected to ensure that there is maintained illumination of the means of egress that are either continuously in operation or capable of automatic operation without manual intervention.</p> <p>Measures or systemic changes to ensure</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 281	Continued From page 4	K 281	that the deficiencies will not recur: The Maintenance Director/Designee will conduct compliance audits to ensure that all areas of the building are inspected to maintain illumination of the means of egress that are either continuously in operation or capable of automatic operation without manual intervention as required. The Maintenance Director/Designee will conduct one weekly audit of three areas of the building for four weeks then two times monthly for two months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.	K 321		5/21/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 321	<p>Continued From page 5</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/05/2025 in the presence of the facility U.S. FOIA (b) (6), it was determined that the facility failed to ensure that hazardous area doors were self-closing or automatic closing in accordance with NFPA 101 2012 Edition, Sections 19.3.2, 19.3.2.1.3 and 19.3.2.1.5. This deficient practice had the potential to affect 22 of 107 residents and was evidenced by the following:</p> <p>An observation at 10:18 PM revealed the whirlpool bathroom door did not have a self-closer or automatic closer. The room was being used for storage of combustible material and was greater than 60 square feet.</p> <p>In an interview at the time, the U.S. FOIA (b) (6) confirmed the observation.</p> <p>The facility's U.S. FOIA (b) (6)</p>	K 321	<p>Residents affected by deficient practice:</p> <p>The facility failed to ensure that hazardous area doors were self-closing or automatic closing in accordance with NFPA 101 2012 Edition, Sections 19.3.2, 19.3.2.1.3 and 19.3.2.1.5.</p> <p>No residents were affected by this deficient practice.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 321	Continued From page 6 U.S. FOIA (b) (6) were notified of the deficient practice at Life Safety Code survey exit conference on 03/25/2025 at 2:35 PM. N.J.A.C. 8:39-31.2 (e)	K 321	On 4/15/2025, the U.S. FOIA (b) (6) was educated by the Administrator on the requirement that hazardous area doors have to be self-closing or automatically close as required. A new door closer was installed on the whirlpool bathroom door on 3/26/2025. All hazardous area doors were inspected to ensure that they meet the requirement for self-closing or close automatically as required. Measures or systemic changes to ensure that the deficiencies will not recur: The Maintenance Director/Designee will conduct compliance audits to ensure that all hazardous area doors are self-closing or automatically close as required. The Maintenance Director/Designee will conduct one weekly audit for four weeks then two times monthly for two months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K 345		5/21/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 345	<p>Continued From page 7</p> <p>accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on documentation review and interview on 03/25/2025 in the presence of the ^{U.S. FOIA (b) (6)} [REDACTED], it was determined that the facility failed to ensure a sensitivity testing of smoke detectors was conducted every alternate year in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect all 107 residents and was evidenced by the following:</p> <p>A document review at 9:45 AM revealed all fire alarm documents from the facility vendor dated: 12/3/2025 and 06/11/2024. The inspection reports did not indicate when the last smoke detector sensitivity testing was conducted.</p> <p>In an interview at 1:15 PM, the ^{U.S. FOIA (b) (6)} stated the facility was unable to provide any documentation of a recent inspection of the fire alarm sensitivity testing of smoke detectors and he was unsure when the last sensitivity testing was conducted by the facility fire alarm vendor.</p> <p>The facility's ^{U.S. FOIA (b) (6)} [REDACTED] were notified of the deficient practice at Life Safety Code survey exit conference at 2:35 PM.</p>	K 345	<p>Residents affected by deficient practice:</p> <p>The facility failed to ensure a sensitivity testing of smoke detectors was conducted every alternate year in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72.</p> <p>No residents were affected by this deficient practice.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the ^{U.S. FOIA (b) (6)} [REDACTED] was educated by the Administrator on the requirement that sensitivity testing of smoke detectors is to be conducted every alternate year.</p> <p>Sensitivity testing of smoke detectors will be conducted on May,21,2025</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
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K 345	Continued From page 8 NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	All smoke detectors were audited to ensure compliance with the requirement. Measures or systemic changes to ensure that the deficiencies will not recur: The Maintenance Director/Designee will conduct compliance audits to ensure that sensitivity testing of smoke detectors is completed as required. The Maintenance Director/Designee will conduct one monthly audit for three months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		5/21/25	

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K 353	<p>Continued From page 9</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 03/24/2025 in the presence of the [U.S. FOIA (b) (6)], it was determined that the facility failed to maintain fire sprinkler heads free from loading from dust and debris in accordance with NFPA 25:2011. This deficient practice had the potential to affect 107 residents and was evidenced by the following:</p> <p>Observations with the [U.S. FOIA (b) (6)] between 11:04 AM and 11:48 AM revealed resident room # [NJ Ex Order 26. 4B1] fire sprinkler heads were loaded with dust.</p> <p>Observations in the kitchen at 11:55 AM revealed 5 of 9 fire sprinkler heads were loaded with a large buildup of grease and dust.</p> <p>In an interview at the time, the [U.S. FOIA (b) (6)] confirmed the observation.</p> <p>The facility's [U.S. FOIA (b) (6)] were notified of the deficient practice at Life Safety Code survey exit conference on 03/25/2025 at 2:35 PM.</p> <p>NJAC 8:39-31.2(e) NFPA 25</p>	K 353	<p>Residents affected by deficient practice:</p> <p>The facility failed to maintain fire sprinkler heads free from loading from dust and debris in accordance with NFPA 25:2011.</p> <p>No residents were affected by this deficient practice.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the [U.S. FOIA (b) (6)] was educated by the Administrator on the requirement to maintain fire sprinkler heads free from loading from dust and debris.</p> <p>Fire sprinkler heads in rooms [NJ Ex Order 26. 4B1] were inspected, cleaned, and dust was cleared to meet the requirement.</p> <p>The 5 fire sprinkler heads identified in the kitchen were inspected, cleaned, and cleared of grease and dust to meet the</p>		

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

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FORM APPROVED
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K 353	Continued From page 10	K 353	<p>requirement.</p> <p>All sprinkler heads were audited to ensure compliance with the requirement.</p> <p>Measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>The Maintenance Director/Designee will conduct compliance audits to ensure that fire sprinkler heads are free from loading from dust and debris as required.</p> <p>The Maintenance Director/Designee will conduct one weekly audit to include three sprinkler heads for four weeks, then two times monthly for two months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.</p>		
K 521 SS=E	<p>HVAC CFR(s): NFPA 101</p> <p>HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</p> <p>This REQUIREMENT is not met as evidenced</p>	K 521		5/21/25	

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K 521	<p>Continued From page 11</p> <p>by: Based on observations and interview on 03/24/2025 in the presence of the [REDACTED], it was determined that the facility failed to ensure resident bathroom ventilation system units were maintained in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice had the potential to affect 46 of 107 residents was evidenced by the following:</p> <p>Observations during the tour between 9:15 AM and 3:28 PM in the presence of the [REDACTED] revealed the [REDACTED] residents' room bathroom ventilation systems were not functioning. The surveyor requested that the [REDACTED] confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue was not held in place by any suction. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation.</p> <p>In an interview at the time, the [REDACTED] confirmed the findings.</p> <p>The facility's [REDACTED] were notified of the deficient practice at Life Safety Code survey exit conference on 03/25/2025 at 2:35 PM.</p> <p>NJAC 8:39-31.2(e) NFPA 90 A</p>	K 521	<p>Residents affected by deficient practice:</p> <p>The facility failed to ensure resident bathroom ventilation system units were maintained in accordance with the National Fire Protection Association (NFPA) 90 A, B.</p> <p>No residents were affected by this deficient practice.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the [REDACTED] was educated by the Administrator on the requirement to maintain resident bathroom ventilation system units in accordance with the National Fire Protection Association (NFPA) 90 A, B.</p> <p>The [REDACTED] residents' room bathroom ventilation system was repaired on 3/24/2025.</p> <p>All residents room bathroom ventilation systems were audited to ensure compliance with the requirement.</p> <p>Measures or systemic changes to ensure that the deficiencies will not recur:</p>		

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K 521	Continued From page 12	K 521	The Maintenance Director/Designee will conduct compliance audits to ensure that resident bathroom ventilation systems are maintained as required. The Maintenance Director/Designee will conduct one weekly audit of all residents room bathroom ventilation systems for four weeks, then two times monthly for two months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.		
K 912 SS=F	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 03/24/2025 in the presence of the [REDACTED], it was determined that the	K 912	Residents affected by deficient practice: The facility failed to ensure that 3 of 5 electrical outlets located next to a water	5/21/25	

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K 912	<p>Continued From page 13</p> <p>facility failed to ensure that 3 of 5 electrical outlets located next to a water source were equipped with Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 70 and 99. This deficient practice had the potential to affect all 107 residents and was evidenced by the following:</p> <p>An observation at 10:45 AM revealed that the coffee machine in the NJ Ex Order 26. 4B1 nourishment room was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations.</p> <p>An observation at 11:47 AM revealed that the coffee machine in the NJ Ex Order 26. 4B1 nourishment room was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations.</p> <p>An observation at 12:37 PM revealed that the ice machine in the kitchen was plugged into a standard duplex wall outlet and not the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations.</p> <p>In an interview at the time, the U.S. FOIA (b) (6) confirmed the observations.</p> <p>The facility's NJ Ex Order 26. 4B1 were notified of the deficient practice at Life Safety Code survey exit conference on 03/25/2025 at 2:35 PM.</p> <p>NJAC 8:39 -31.2 (e) NFPA 70, 99</p>	K 912	<p>source were equipped with Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 70 and 99.</p> <p>No residents were affected by this deficient practice.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the U.S. FOIA (b) (6) was educated by the Administrator on the requirement that electrical outlets located next to a water source have to be equipped with Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 70 and 99.</p> <p>A new wall outlet in the NJ Ex Order 26. 4B1 nourishment room was installed to meet the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations on 3/27/2025 to allow the coffee machine to be plugged in it.</p> <p>A new wall outlet in the NJ Ex Order 26. 4B1 nourishment room was installed to meet the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations on 3/27/2025 to allow the coffee machine to be plugged in it.</p>		

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K 912	Continued From page 14	K 912	<p>A new wall outlet in the kitchen was installed to meet the required Ground Fault Circuit Interrupter (GFCI) electrical outlet for wet locations on 3/27/2025 to allow the ice machine to be plugged in it.</p> <p>All electrical outlets located next to a water source were inspected to ensure they are equipped with Ground-Fault Circuit Interrupter (GFCI) protection in accordance with NFPA 70 and 99.</p> <p>Measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>The Maintenance Director/Designee will conduct compliance audits to ensure electrical outlets located next to a water source are equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required.</p> <p>The Maintenance Director/Designee will conduct one weekly audit to include three electrical outlets for four weeks, then two times monthly for two months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.</p>		
K 918 SS=F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing</p>	K 918		5/21/25	

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K 918	<p>Continued From page 15</p> <p>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on documentation review and interview on 03/25/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to exercise the emergency generator under load for 4 continuous hours every 36</p>	K 918	<p>Residents affected by deficient practice:</p> <p>The facility failed to exercise the emergency generator under load for 4 continuous hours every 36 months in</p>		

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K 918	<p>Continued From page 16</p> <p>months in accordance with NFPA 101: 2012 Edition, NFPA 99: 2012 Edition, Sections 6.4.4, 6.5.4,6.6.4, and NFPA 110: 2010 Edition, Section 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7. This deficient practice had the potential to affect all 107 residents and was evidence by the following:</p> <p>A review of the emergency generator log at 12:10 PM with the [U.S. FOIA (b) (6)], revealed the facility had no documentation of a continuous 4-hour load test of the generator over the last 36 months. No further documentation was provided indicating the test was conducted.</p> <p>In an interview at 1:15 PM, the [U.S. FOIA (b) (6)] confirmed the review.</p> <p>The facility's [U.S. FOIA (b) (6)] were notified of the deficient practice at Life Safety Code survey exit conference at 2:35 PM.</p> <p>NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110</p>	K 918	<p>accordance with NFPA 101: 2012 Edition, NFPA 99: 2012 Edition, Sections 6.4.4, 6.5.4,6.6.4, and NFPA 110: 2010 Edition, Section 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7.</p> <p>No residents were affected by this deficient practice.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>On 4/15/2025, the [U.S. FOIA (b) (6)] was educated by the Administrator on the requirement to exercise the emergency generator under load for 4 continuous hours every 36 months.</p> <p>A service company was contracted on 3/27/2025 to exercise the emergency generator to meet the requirement.</p> <p>Measures or systemic changes to ensure that the deficiencies will not recur:</p> <p>The Maintenance Director/Designee will conduct compliance audits to ensure that the requirement to exercise the emergency generator under load for 4 continuous hours every 36 months is met</p> <p>The Maintenance Director/Designee will</p>		

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K 918	Continued From page 17	K 918	conduct one monthly audit for three months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.		
K 921 SS=F	<p>Electrical Equipment - Testing and Maintenance CFR(s): NFPA 101</p> <p>Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use</p>	K 921		5/21/25	

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K 921	<p>Continued From page 18 of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 03/24/2025 and 03/25/2025 in the presence of the <u>U.S. FOIA (b) (6)</u>, it was determined that the facility failed to provide the required electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all 107 residents and was evidenced by the following:</p> <p>1). Observations on 3/24/25 from 9:15 AM to 3:15 PM revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility</p> <p>In an interview at 3:20 PM, the <u>U.S. FOIA (b) (6)</u> confirmed the observations and at that time policies and protocols for patient-care related equipment were requested by the surveyor.</p> <p>2). A documentation review on 3/25/25 revealed no policy on patient care related electrical equipment.</p> <p>Documentation provided by the facility's Administrator at Life Safety Code survey exit conference at 2:30 PM had no references to</p>	K 921	<p>Residents affected by deficient practice:</p> <p>The facility failed to provide the required electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8.</p> <p>No residents were affected by this deficient practice.</p> <p>Identify those individuals who could be affected by the deficient practice:</p> <p>All residents have the potential to be affected.</p> <p>What corrective action will be accomplished for those residents affected by the deficient practice:</p> <p>Facility updated policy on all the patient care related electrical equipment (PCREE) to include conducting maintenance of electrical equipment and maintaining a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT ARBORS			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 921	Continued From page 19 patient-care related equipment. The facility's U.S. FOIA (b) (6) were notified of the deficient practice at Life Safety Code survey exit conference at 2:35 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. On 4/15/2025, the U.S. FOIA (b) (6) was educated by the Administrator on the policy and the requirement to conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs. An audit of all patient care related electrical equipment was completed on 4/18/2025 and no concerns were found. All results were recorded in the maintenance log. Measures or systemic changes to ensure that the deficiencies will not recur: The Maintenance Director/Designee will conduct compliance audits to ensure that the requirement is met. The Maintenance Director/Designee will conduct one weekly audit to include three PCREE for four weeks then two times monthly for two months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315333	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 5/22/2025
Y1	Y2	Y3
NAME OF FACILITY COMPLETE CARE AT ARBORS		STREET ADDRESS, CITY, STATE, ZIP CODE 1750 ROUTE 37 WEST TOMS RIVER, NJ 08757

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	05/21/2025	LSC K0281	05/21/2025	LSC K0321	05/21/2025
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	05/21/2025	LSC K0353	05/21/2025	LSC K0521	05/21/2025
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0912	05/21/2025	LSC K0918	05/21/2025	LSC K0921	05/21/2025
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/27/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		