STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315316	A. BUILDING _____ B. WING _____	C 07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRAKELEY PARK, LLC	**290 RED SCHOOL LANE PHILLIPSBURG, NJ 08865**

(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 #: NJ144974 and NJ144286 Census: 95 Sample Size: 8 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		8/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/10/2021

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 609	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint NJ144286 Based on interviews, record review, and police report review, it was determined that the facility failed to report an alleged violation of verbal abuse to the New Jersey Department of Health (NJDOH) for 1 (Resident #1) of 4 residents reviewed for abuse. Specifically, the facility failed to report allegations of staff to resident verbal abuse against Resident #1. Findings included: 1. Resident #1 was admitted on [redacted] with diagnoses including [redacted]. The admission Minimum Data Set, dated [redacted] revealed the resident was [redacted] with a Brief Interview for Mental Status (BIMS) score of [redacted] The resident required one-person physical assistance with bed mobility, locomotion, dressing, and personal hygiene. The resident required two-persons physical assistance with transfer and toilet use. A review was conducted of an incident report completed by the facility following the allegation of the nurse supervisor's (NS) conduct with Resident #1. The report revealed the NS notified the facility's administration of her encounter with Resident #1 and how the resident's family took	F 609	1) Resident #1 is no longer in the facility. 2) All residents in the center have the ability to be affected by this practice. 3) All staff have the potential to report alleged violations of abuse. All staff in the center have been inserviced on abuse prohibition and the reporting requirements. 4) The facility will conduct interdisciplinary clinical rounds at least three times a week for eight weeks. The interdisciplinary team includes but it not limited to the Administrator, Director of Nursing, Unit Managers and Social Services. The facility will review patient records and ensure that all potential unreported allegations of abuse are identified and reported. All findings will be reported and reviewed by the QAPI committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315316	A. BUILDING _____ B. WING _____	C 07/20/2021

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COMPLETE CARE AT BRAKELEY PARK, LLC	**290 RED SCHOOL LANE PHILLIPSBURG, NJ 08865**

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F 609	Continued From page 2	F 609		

the interaction. The record revealed the facility's administration spoke with Resident #1's family member, who was the individual who overheard the NS's interactions with Resident #1. The family member advised the facility that although the individual heard the NS speak loudly toward Resident #1 while the family member was having a conversation with the resident, the family member clarified to the facility that the NS was not heard to have used profanity, threatened, attempted to curse, or used abusive language towards Resident #1.

There was no facility reported event (FRE) to the NJDOH for this allegation.

A review of the police report dated 03/30/2021 which was on file at the facility revealed the responding officer spoke with Resident #1 who reported that the resident had gotten into an argument with the NS while the resident was on the phone with a family member.

On 07/20/2021 at 4:51 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were interviewed. The NHA stated that an investigation was started immediately when they were made aware of the alleged abuse with Resident #1. He said his investigation concluded that Resident #1 was not verbally abused by the NS. The NHA reiterated how the facility accommodated for Resident #1's [redacted] and stated he believed it was [redacted]. The NHA said he did not report an alleged abuse to the NJDOH after having carefully reviewed the facts and interviews with Resident #1 and the resident's family member. The NHA acknowledged that the regulatory language under F609 did not require that the facility investigate an

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F 609	Continued From page 3 abuse allegation before it reported the alleged abuse to the NJDOH. New Jersey Administrative Code § 8:39-5.1(a)	F 609		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315316		8/20/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRAKELEY PARK, LLC	290 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

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 F0609 Reg. # 483.12(c)(1)(4) LSC	Correction Completed 08/20/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
7/20/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO