STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

(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 Complaints NJ #: 157735; 160630; 161027; 164199; 169902; 170619; 172027 Survey Date: 5/29/24 Census: 158 Sample: 32 + 3 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		7/19/24

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

Electronically Signed | 06/10/2024

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to notify the New Jersey Department of Health (NJDOH) an NJ Ex Order 26.4(b)(of NJ Ex Order 26.4 for a US FOIA (b)(6) who was discovered NJ Ex Order 26.4(b) during a shift in a NJ Ex Order 26.4(b)(1) who reported they were NJ Ex Order 26.4(b)(1) of a NJ Ex Order 26.4(b)(1) This deficient practice was identified for 1 of 6 NJ Ex Order 26.4b1 employee files reviewed, and was evidenced by the following: During entrance conference on 5/20/24 at 9:54 AM, the surveyor asked the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide the survey team with a list of all employees hired since last standard survey who were still employed by the facility or NJ Ex Order 26.4b1. The surveyor requested the facility provide the reason for NJ Ex Order 26.4b1. On 5/24/24 at 9:35 AM, the surveyor requested from the U.S. FOIA ten employee files including personal and medical from the provided list. A review of CNA #1's files revealed the following: The employee was hired on NJ Ex Order 26.4(b, with an Employee NJ Ex Order 26.4b1 form dated effective NJ Ex Order 26.4, with a NJ Ex Order 26.4b1 summary for "staff	F 609	F609 Reporting of Alleged Violations Residents affected by deficient practice: The facility failed to notify the New Jersey Department of Health (NJDOH) an allegation of neglect for a Certified Nursing Aide, CNA #1, who was discovered NJ Exec Order 26.4 during a shift in a resident's NJ Exec Or who reported they were under the NJ Exec Order 26.4b1. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: All residents were monitored for any adverse effects with none noted. CNA #1 is no longer employed at the facility. The facility notified the New Jersey Department of Health on NJ Ex Order 26.4b1. US FOIA (b)(6) were reeducated on 6/4/2024 by the Regional Administrator on	

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F 609	Continued From page 2 was observed to be NJ Ex Order 26.4b1 . According to her, she stated she took too much of her NJ Ex Order 26.4(b)(1)] and never brought in a script." A review of the New Employee NJ Ex Order 26.4(Examination signed by CNA #1 on NJ Ex Order 26.4(b) indicated for list of medical conditions was left blank, and the list of all medications you are currently using and indication of use did not include NJ Ex Order 26.4(b)(1). On 5/28/24 at 11:40 AM, the surveyor interviewed the U.S. FOIA regarding CNA #1's NJ Ex Order 26.4b1, and the U.S. FOIA stated she received a phone call from the U.S. FOIA (b) (6) that aide was NJ Ex Order 26.4(b)(1) and she was NJ Ex Order 26.4(b)(1) in NJ Ex Order 26.4(b)(1). Staff woke CNA #1 up and she stated she was tired and went back to work, but was found NJ Ex Order 26.4(so she was sent home. The U.S. FOIA stated she spoke to CNA #1 the next day who stated she said had been under NJ Ex Order 26.4(b)(1), and she took too much of her NJ Ex Order 26.4(b)(1). The U.S. FOIA requested a copy of the prescription, and the CNA stated she would provide the medication bottle, but she never did. The U.S. FOIA stated when the facility suspected an employee NJ Ex Order 26.4b1 they were sent out to the hospital for NJ Ex Order 26.4b1, but the facility did not NJ Ex Order 26.4b1 CNA #1 because the aide stated she had a NJ Ex Order 26.4(b)(1) that was never confirmed and the CNA could not provide the name of the NJ Ex Order 26.4(b)(1). The DON stated CNA #1 never brought in the NJ Ex Order 26.4(b)(1) so she never worked again, and the U.S. FOIA confirmed she did not report the CNA's condition to any agency or licensing boards since the CNA was "just NJ Ex Order 26.4 The U.S. FOIA stated she was unsure who in the state would be notified.	F 609	the requirements of reporting and investigating allegations of neglect and on the following facility policies: Abuse, Neglect, Exploitation and Misappropriation Prevention Program and Substance Abuse in the Workplace. All terminated employee files were audited by the Human Resources Director and ensured compliance with these policies. The Director of Nursing, and Licensed Nursing Home Administrator conducted patient interviews on various units and ensured that there were no concerns regarding any staff members, suspected neglect, and abuse with no concerns voiced. Measures or systematic changes to ensure that the deficiencies will not reoccur: The Human Resources Director or Designee will conduct audits of 3 terminated employee files to ensure that any allegations of neglect are reported and investigated as required, and that all reportable events and the following of the policy and procedures are completed. Audits will be completed weekly X 4 weeks then monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 609	Continued From page 3	F 609		

At that time, the surveyor requested a copy of CNA #1's assignment sheet for the day, as well as their time card, and the facility's policy regarding an employee NJ Ex Order 26.4(b)(1).

A review of CNA #1's time card revealed the last day she worked was NJ Ex Order 26.4(b) from 4:49 PM until 10:45 PM.

A review of the CNA Assignment sheet for the 3:00 PM to 11:00 PM shift on NJ Ex Order 26.4(b), revealed CNA #1 was assigned fourteen residents, which included twelve residents who needed assistance with transferring from bed to chair or chair to bed with five of the residents using a hoyer lift (an assistive device that uses a sling to lift the resident in the air to be transferred between a bed and chair).

On 5/28/24 at 2:05 PM, the U.S. FOIA in the presence of the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), and survey team, stated the incident with CNA #1 occurred on NJ Ex Order 26.4(b), and the CNA returned to the facility the next day to speak with the U.S. FOIA (b) The U.S. FOIA stated CNA #1 stated she was on an NJ Ex Order 26.4(b)(1) that the aide was unsure of the name, and never provided the NJ Ex Order 26.4(b)(1) The U.S. FOIA could still not speak to who the incident should have been reported to.

On 5/29/24 at 10:13 AM, the U.S. FOIA (b) in the presence of the U.S. FOIA (b) U.S. FOIA (b) (6), U.S. FOIA (b) (6) and survey team stated the facility would report the incident to the NJDOH. The U.S. FOIA stated that CNA #1 at the beginning of her shift was fine, and staff noticed at the end of the shift she was NJ Ex Order 26.4(b)(1). The U.S. FOIA confirmed she

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F 609	Continued From page 4 was found [NJ Ex Order 26.4(b)] in a [NJ Ex Order 26.4(b)(1)], and that the [U.S. FOIA (b) (6)] had called her that evening because she was concerned with the CNA. The [U.S. FOIA] confirmed the CNA had a full assignment of residents, and someone [NJ Ex Order 26.4(b)] by a [NJ Ex Order 26.4(b)(1)] should not be operating a [NJ Exec Order 26.4] because it was a safety concern. A review of the facility's "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" dated reviewed January 2024, included protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not limited to: a. facility staff...identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property; investigate and report any allegations within the timeframes required by federal requirements... A review of the facility's "Substance Abuse in the Workplace" policy dated 2020, included the facility is committed to ensuring a drug and alcohol-free workplace in order to maintain the safety of its residents...being under the influence of alcohol or illegal drugs while at the facility poses a serious health and safety risk to all residents...staff may not present in the Facility...conduct any Facility-sanctioned task while impaired on a substance...this policy does not prohibit appropriate use of over the counter and legal prescription medication when used to treat a disability...nothing in this policy is meant to prohibit the appropriate use of over-the-counter medication or other medication that can legally be prescribed under both federal and state law, to the extent that it does not impair a staff member's job performance or safety or safety of others...a violation of this policy is subject to disciplinary	F 609		

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F 609	Continued From page 5 action, up to and including termination of employment. NJAC 8:39-4.1(a)5	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to investigate an [redacted] of [redacted] when a US FOIA (b)(6) was discovered [redacted] during shift in a [redacted] who reported they were NJ Ex Order 26.4(b)(1) of a [redacted] This deficient practice was identified for 1 of 6 [redacted] employee files reviewed, and was evidenced by the following:	F 610	F 610 Investigate / Prevent / Correct Alleged Violations Residents affected by deficient practice: " The facility failed to investigate an allegation of neglect when a Certified Nursing Aide, CNA #1, was discovered [redacted] during shift in a resident's room who reported they wer [redacted]	7/19/24

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F 610	Continued From page 6 During entrance conference on 5/20/24 at 9:54 AM, the surveyor asked the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide the survey team with a list of all employees hired since last standard survey who were still employed by the facility or NJ Exec Order 26.4b1 The surveyor requested the facility provide the reason for NJ Exec Order 26.4b1 On 5/24/24 at 9:35 AM, the surveyor requested from the U.S. FOIA ten current and NJ Exec Order 26.4b1 employee files including personal and medical from the provided list. A review of CNA #1's files revealed the following: The employee was hired on NJ Ex Order 26.4(b, with an Employee NJ Exec Order 26.4b1 form dated effective NJ Ex Order 26.4, with a NJ Exec Order 26.4b1 summary for "staff was observed to be NJ Ex Order 26.4(b)(1) of a NJ Ex Order 26.4(b)(1) According to her, she stated she took too much of her[NJ Ex Order 26.4(b)(1)] and never brought in a NJ Ex Order 26 A review of the New Employee NJ Ex Order 26.4(b Examination signed by CNA #1 on NJ Ex Order 26.4(b), indicated for list of medical conditions was left blank, and the list of all medications you are currently using and indication of use did not include NJ Ex Order 26.4(b)(1). On 5/28/24 at 11:40 AM, the surveyor interviewed the U.S. FOIA regarding CNA #1's NJ Ex Order 26.4b1, and the U.S. FOIA stated she received a phone call from the U.S. FOIA (b) (6) that aide was NJ Ex Order 26.4(b)(1) and she was NJ Ex Order 26.4(b)(1) in a NJ Ex Order 26.4(b)(1). Staff woke CNA #1 up and she stated she was NJ Ex Ord and went back to work, but was found NJ Ex Order 26.4(b again so she was sent home. The U.S. FOIA stated	F 610	Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: " All residents were monitored for any adverse effects with none noted. " CNA #1 is no longer employed at the facility. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were re-educated on 6/4/2024 by the Regional Licensed Nursing Home Administrator on the requirements of reporting and investigating allegations of neglect and on the following facility policies: Accident/ Incident Reporting, Abuse, Neglect, Exploitation and Misappropriation Prevention Program and Substance Abuse in the Workplace. Emphasis on the reporting and investigating events according to the long-term regulations, NJ DOH Guidelines/ Reportable Grid and the facility policy. With prompt reporting to NJDOH to be done by the Administrator/DON or the designee as per regulation guidelines. The facility completed a full investigation. " All terminated employee files were audited by the Human Resources Director and ensured compliance with these policies. Measures or systematic changes to ensure that the deficiencies will not	

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F 610	Continued From page 7 she spoke to CNA #1 the next day who stated she said had been NJ Exec Order 26.4b1, and she took too much of her NJ Exec Order 26.4b1. The U.S. FOIA requested a copy of the prescription, and the CNA stated she would provide the medication bottle, but she never did. The U.S. FOIA stated when the facility suspected an employee being NJ Exec Orde they were sent out to the hospital for NJ Ex Order 26.4b1, but the facility did not NJ Ex Order 26.4b1 CNA #1 because the aide stated she had a NJ Ex Order 26.4(b)(1) that was never confirmed and the CNA could not provide the name of the prescribed medication. The U.S. FOIA stated CNA #1 never brought in the NJ Ex Order 26.4(b)(1) so she never worked again, and the U.S. FOIA confirmed she never took any statements from employees or conducted an investigation. At that time, the surveyor requested a copy of CNA #1's assignment sheet for the day, as well as their time card, and the facility's policy regarding an employee NJ Ex Order 26.4(b)(1). A review of CNA #1's time card revealed the last day she worked was NJ Ex Order 26.4(b from 4:49 PM until 10:45 PM. A review of the CNA Assignment sheet for NJ Ex Order 26.4(b, revealed CNA #1 was assigned fourteen residents, which included twelve residents who needed assistance with transferring from bed to chair or chair to bed with five of the residents using a NJ Exec Orde lift (an assistive device that uses a sling to lift the resident in the air to be transferred between a bed and chair). On 5/28/24 at 2:05 PM, the U.S. FOIA in the presence of the U.S. FOIA (b) (6) U.S. FOIA (b) (6)), U.S. FOIA (b) (6), U.S. FOIA (b) (6), and	F 610	reoccur: " The DON/HR Director /Designee will conduct audits of employee files to ensure that any allegations of neglect are reported and investigated as required and the following of the policy and procedures on reporting and investigating reportable events. Audits of 3 employee files will be completed weekly X 4 weeks then monthly x 2 months. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 610	Continued From page 8	F 610		

survey team, stated the incident with CNA #1 occurred on [redacted], and the CNA returned to the facility the next day to speak with the [redacted] The [redacted] stated CNA #1 stated she was on an NJ Ex Order 26.4(b)(1) that the aide was unsure of the name, and never provided the [redacted] The [redacted] confirmed she obtained no written statements from any staff.

On 5/29/24 at 10:13 AM, the [redacted] in the presence of the [redacted] U.S. FOIA (b) (6), [redacted], and survey team stated that CNA #1 at the beginning of her shift was fine, and staff noticed at the end of the shift she was [redacted]. The [redacted] confirmed she was found [redacted] in a [redacted], and that the [redacted] had called her that evening because she was concerned with CNA. The [redacted] confirmed the CNA had a full assignment of residents, and someone [redacted] by a [redacted] should not be operating a [redacted] lift because it was a safety concern.

A review of the facility's "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" dated reviewed January 2024, included protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not limited to: a. facility staff...identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property; investigate and report any allegations within the timeframes required by federal requirements...

A review of the facility's "Substance Abuse in the Workplace" policy dated 2020, included the facility is committed to ensuring a drug and alcohol-free workplace in order to maintain the

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F 610	Continued From page 9 safety of its residents...being under the influence of alcohol or illegal drugs while at the facility poses a serious health and safety risk to all residents...staff may not present in the Facility...conduct any Facility-sanctioned task while impaired on a substance...this policy does not prohibit appropriate use of over the counter and legal prescription medication when used to treat a disability...nothing in this policy is meant to prohibit the appropriate use of over-the-counter medication or other medication that can legally be prescribed under both federal and state law, to the extent that it does not impair a staff member's job performance or safety or safety of others...a violation of this policy is subject to disciplinary action, up to and including termination of employment. NJAC 8:39-4.1(a)5	F 610		
F 677 SS=E	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 NJ#: 160630; 169902; 170619; 172027 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure that [redacted] care was provided to [redacted] residents for 5 of 8 residents observed during	F 677	F677 ADL Care for Provided for Dependent Residents Resident affected by deficient practice: The facility failed to a.) ensure that [redacted] care was provided to [redacted] residents for 5 of 8 residents observed during [redacted] rounds (Residents #94, #16, #8, #109 and #137)	7/10/24

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COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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F 677	Continued From page 10 NJ Ex Order 26.4(b)(1) rounds (Residents #94, #16, #8, #109 and #137) on 1 of 2 nursing units (Applewood), and b.) provide activities of daily living (ADL) care for 4 of 7 residents reviewed for ADL care (# 95, #94, #109 and #16). This deficient practice was evidenced by the following: 1. On 5/20/24 at 11:41 AM, the surveyor observed Resident #94 in bed. The Resident's Representative (RR #1) informed the surveyor that Resident #94 had not received care that morning, which included NJ Ex Order 26.4(b)(1) care, and was still NJ Ex Order 26.4(b)(1) from last night. At that time, Resident #94 nodded in agreement. On 5/20/24 at 11:52 AM, the surveyor found Resident #94's Certified Nursing Assistant (CNA #1) who confirmed she was the resident's aide for the day, and stated she had provided NJ Ex Order 26.4b1 earlier that shift. The surveyor accompanied by CNA #1, entered the resident's room and pulled back the resident's blanket. It was revealed that the resident was NJ Ex Order 26.4(b)(1) that NJ Ex Order 26.4(b)(1) through their NJ Ex Order and NJ Ex Order 26.4(b)(1). At that time, the surveyor observed a NJ Ex Order 2 . CNA #1 stated she had not provided care yet for that resident, and was previously mistaken. CNA #1 further stated that she had ten residents on her assignment that day and had not provided care. Review of the CNA assignment sheet revealed the unit had a census of 51 Residents with five assigned aides. CNA #1 had an assignment of ten residents on that shift. The surveyor reviewed the medical record for	F 677	on 1 of 2 nursing units (Applewood), and b.) provide activities of daily living (ADL) care for 4 of 7 residents reviewed for ADL care (#95, 94, #109 and #16). Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: Residents #94, #16, #8, #109, and #137 were provided with the appropriate NJ Ex Order 26.4(b)(1) care and residents #95 and #94 received NJ Ex Order 26.4b per their preferences as scheduled. Residents #109 and #16 had their nails clipped and cleaned as required. All residents were monitored for any adverse effects with none noted. Director of Nursing conducted facility wide audit to ensure that all patients have had their most recent scheduled shower, proper incontinence care, and had nail care completed as required per facility s policy. All Registered Nurses, Licensed Practical Nurses and Certified Nurses Aides were reeducated by the Director of Nursing on 6/4/2024 on facility policies: Activities of Daily Living (ADLs) Supporting to ensure compliance with the requirement. Measures or systematic changes to ensure that the deficiencies will not recur: The Director of Nursing or Designee will conduct 2 audits weekly for 4 weeks, then	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11 Resident #94. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4 [redacted], reflected the resident had a brief interview for mental status (BIMS) score of NJ Ex [redacted] out of 15, which indicate NJ Ex Order 26.4(b)(1) [redacted] from staff for NJ Ex Order 26.4(b)([redacted] and NJ Ex Order 26.4 [redacted] and was frequently NJ Ex Order 26.4(b)(1) and occasionally NJ Ex Order 26.4(b)(1). A review of the individualized comprehensive care plan (ICCP) dated NJ Ex Order 26.4(b [redacted], included a focus area that the resident was at risk for NJ Ex Or [redacted] related to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Interventions included to change NJ Ex Order 26.4(b)(1) product as soon as possible (ASAP) after NJ Ex Order 26 [redacted] or NJ Ex Order 26.4(b)(1); keep NJ Ex Order 26.4(b) [redacted]; keep NJ Ex Order 26.4(b)(1). An additional focus area dated NJ Ex Order 26.4(b [redacted], included NJ Ex Order 26.4(b)(1) with interventions that included to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b [redacted] and assistance with NJ Ex Order 26.4(b [redacted] from NJ Ex Order 2 [redacted] and NJ Ex Order 26.4(b)(1) On 5/22/24 at 7:23 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] who stated that NJ Ex Order 26.4(b)(1) rounds should be completed every two hours. On 5/24/24 at 10:17 AM, the surveyor interviewed	F 677	bi-weekly for 2 months to ensure that residents are receiving showers, incontinence care, and nail care as scheduled and appropriate. Results of all audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessment for further action.	

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the U.S. FOIA (b) (6)) who confirmed that NJ Ex Order 26.4b1 should be done every two hours on the day shift.

On 5/29/24 at 10:13 AM, the U.S. FOIA in the presence of the U.S. FOIA (b) (U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b)(1) care should be provided every two hours.

2. On 5/22/24 at 7:45 AM, the surveyor performed NJ Ex Order 26.4(b)(1) rounds with the U.S. FOIA (b) (6) on the NJ Exec Order 26.4b1 Unit and observed Resident #16 in bed with an NJ Ex Order 26.4(b)(1) NJ Ex Ord that was NJ Ex Order 26.4b1 with NJ Ex Orde. The surveyor and U.S. FOIA (b) (6) observed a NJ Ex Order 26.4(b)(1). At that time, the U.S. FOIA (b) (6) confirmed that the NJ Ex Ord should have been NJ Ex Order 26.4(b) every two hours and agreed that, given the extent of the NJ Ex Order 26.4(b)(1) the resident's NJ Ex Ord could not have been changed at 5:00 AM.

Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides on the 11:00 PM to 7:00 AM (11-7) shift. The resident's assigned CNA (CNA #2) had an assignment of 18 residents on that shift.

The surveyor reviewed the medical record of Resident #16.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4 (NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b) NJ Ex Order 26.) following NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1).

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NJ Ex Order 26.4(b)(1)

[redacted] 9:24 AM, the surveyor attempted a phone interview with the CNA #2 with no answer.

On 5/24/24 at 10:17 AM, the surveyor interviewed the U.S. FOIA who confirmed that NJ Ex Order 26.4(b)(1) care should be provided every two hours on the day shift and twice on the night shift. The first NJ Ex Order 26.4(b)(1) rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM.

On 5/29/24 at 10:13 AM, the U.S. FOIA in the presence of the U.S. FOIA (b) U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b)(1) care should be provided every two hours.

3. On 5/20/24 at 12:13 PM, the surveyor observed Resident #8 in their room seated in a wheelchair. The Resident's Representative (RR #2) stated that on Saturday, he/she observed the resident's clothing was NJ Ex Order 26.4(b)(1) and observed a NJ Ex Order 26.4(b)(1) on the floor under

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their wheelchair.

On 5/21/24 at 10:44 AM, the surveyor observed Resident #8 in his/her room seated in a wheelchair with CNA #3 in the room. The surveyor observed a NJ Ex Order 26.4(b)(1) in the room. CNA #3 acknowledged the NJ Ex Orde and confirmed that the resident's NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) were all NJ Ex Order 26.4(b)(. Upon making this observation, CNA #3 stated, "not sure what night shift does." CNA #3 further acknowledged that it was her first NJ Ex Order 26.4(b)(1) care provided for Resident #8 for that day.

On 5/22/24 at 7:41 AM, during the NJ Ex Order 26.4(b)(1) rounds, the surveyor observed the resident with an NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) pads that were NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) the NJ Ex Ord . At that time, the surveyor interviewed the U.S. FOIA (b) (6) who stated that placing NJ Ex Order 26.4(b)(1) inside a NJ Ex Order 2 was unacceptable and that it could cause NJ Exec Order 26.4b1.

Review of the 11-7 CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift.

The surveyor reviewed the medical record of Resident #8.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

A review of the most recent comprehensive MDS

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dated NJ Ex Order 26.4(b) reflected the resident had a BIMS score of NJ out of 15, which indicated a NJ Ex Order 26.4(b)(1) hygiene.

A review of the ICCP included a focus area dated NJ Ex Order 26.4, that the resident had the potential for NJ Ex Order 26.4(b)(1) with regards to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Interventions included to change NJ Ex Order 26.4(b)(1) product ASAP after NJ Ex Order 26. or NJ Ex Order ; keep NJ Ex Order 26.4(b)(1) and free of wrinkles; keep NJ Ex Order 26.4(b)(1 and NJ Ex O An additional focus area dated NJ Ex Order 26.4(included ADL with interventions that included assistance of staff member for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(

On 5/23/23 at 9:30 AM, the surveyor attempted a phone interview with the CNA #4 with no answer.

On 5/24/24 at 10:17 AM, the surveyor interviewed the U.S. FOIA who confirmed that NJ Ex Order 26.4(b)(1) care should be provided every two hours on the day shift and twice on the night shift. The first NJ Ex Order 26.4(b)(1) rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM.

On 5/29/24 at 10:13 AM, the U.S. FOIA in the presence of the U.S. FOIA (b) U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b)(1) care should be provided every two hours and that NJ Ex Order 26. pads should not be placed inside U.S. FOIA (b) (6) unless requested by the family or the resident. The U.S. FOIA acknowledged that inserting NJ Ex Order 26.4(b)(1) inside NJ Ex Order 26.4(b)(1) increased the chance of NJ Ex Order 26.4(b)(1).

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F 677	Continued From page 16 4. On 5/22/24 at 7:32 AM, during NJ Ex Order 26.4(b)(1) rounds with the U.S. FOIA (b) (6) on the NJ Exec Order 26.4b1 Unit, Resident #109 was observed in bed wearing an NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1) inside. Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift which included Resident #109. The surveyor reviewed the medical record for Resident #109. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) A review of the most recent comprehensive MDS dated NJ Ex Order 26.4(b) reflected the resident had NJ Ex Order 26.4(b) and required NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) A further review reflected that the resident was NJ Ex Order 26.4(b)(1) of NJ Ex Order 2 and NJ Ex Order 26.4(b) A review of the ICCP included a focus area dated 1/3/22, that the resident was at risk for NJ Ex Order 26.4(b) development due to a NJ Ex Order 26.4(b)(1). Interventions included to keep NJ Ex Order 26.4(b)(1) and NJ Ex Order and change NJ Ex Order 26.4(b)(1) product ASAP after NJ Ex Order 26. or NJ Ex Order 26.4(b)(1). On 5/24/24 at 10:17 AM, the surveyor interviewed the U.S. FOIA who confirmed that NJ Ex Order 26.4(b)(1) care should be provided every two hours on the day shift and twice on the night shift. The first NJ Ex Order 26.4(b)(1) rounds should be done between	F 677		

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12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM.

On 5/29/24 at 10:13 AM, the [U.S. FOIA] in the presence of the [U.S. FOIA (b) (6)], and [U.S. FOIA (b) (6)] acknowledged [NJ Ex Order 26.4(b)(1)] should be provided every two hours and that [NJ Ex Order 26.4(b)(1)] should not be placed inside [NJ Ex Order 26.4(b)(1)] unless requested by the family or the resident. The [U.S. FOIA] acknowledged that [NJ Ex Order 26.4(b)(1)] inside [NJ Ex Order 26.4(b)(1)] [redacted] increased the chance o[NJ Ex Order 26.4(b)(1)].

5. On 5/22/24 at 7:36 AM, during [NJ Ex Order 26.4(b)(1)] rounds, the surveyor and [U.S. FOIA (b) (6)] observed Resident #137 in bed with an [NJ Ex Order 26.4(b)(1)] and a [NJ Ex Order 26.4(b)(1)] inside the [NJ Ex Order 26]

Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift which included Resident #137.

The surveyor reviewed the medical record of Resident #137.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included [NJ Ex Order 26.4(b)(1)] [redacted] and [NJ Ex Order 26.4(b)(1)].

A review of the most recent comprehensive MDS dated [NJ Ex Order 26.4], reflected the resident had a BIMS score of [NJ] out of 15, which indicated [NJ Ex Order 26.4(b] [redacted]. A further review revealed the resident required [NJ Ex Order 26.4(b)(1)] with [NJ Ex Order 26.4] and [NJ Ex Order 26.4(b)]

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A review of the ICCP included a focus area dated [redacted], that the resident required assistance with ADLs with interventions that included to [redacted] with [redacted] and NJ Ex Order 26.4(b)(1).

On 5/24/24 at 10:17 AM, the surveyor interviewed the [redacted] who confirmed that NJ Ex Order 26.4(b)(1) should be provided every two hours on the day shift and twice on the night shift. The first NJ Ex Order 26.4(b)(1) should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM.

On 5/29/24 at 10:13 AM, the [redacted] in the presence of the [redacted] U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b)(1) should be provided every two hours and that NJ Ex Order 26.4(b)(1) should not be placed [redacted] unless requested by the family or the resident. The [redacted] acknowledged that inserting NJ Ex Order 26.4(b)(1) inside NJ Ex Order 26.4(b)(1) [redacted] increased the chance of NJ Ex Order 26.4(b)(1).

6. On 5/20/24 at 11:41 AM, the surveyor interviewed Resident #95 who stated that he/she did not receive their NJ Ex Order 26.4(b)(1) on Friday [redacted], and their last reported [redacted] was on Tuesday [redacted]. Resident #95 stated that their [redacted] were scheduled weekly for Tuesdays and Fridays, but the facility was often short-staffed, and he/she was "lucky" if they even get NJ Ex Order 26.4(b)(1) per week.

The surveyor reviewed the medical record for Resident #95.

A review of the Admission Record face sheet reflected that the resident was admitted to the

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facility with diagnoses that included [redacted], [redacted] and chronic [redacted].

A review of the most recent quarterly MDS dated [redacted], reflected the resident had a BIMS score of [redacted] out of 15, which indicated a [redacted]. A further review revealed the resident required [redacted] for [redacted].

A review of the ICCP included a focus area dated [redacted], that the resident needed [redacted] with ADLs with interventions that included to provide [redacted] to complete [redacted] or [redacted].

On 5/28/24 at 10:10 AM, the surveyor interviewed CNA #5 who informed the surveyor that resident [redacted] days were listed on each of the CNA's assignments. CNA #5 further stated that when a [redacted] was done, the CNAs signed the [redacted] Sheet which was kept in a notebook.

On 5/28/24 at 10:15 AM, the surveyor interviewed the [redacted] who provided the surveyor with copies of Resident #95's [redacted] Sheets. A review of the [redacted] sheets revealed that Resident #95 had not received their scheduled [redacted] on [redacted] or [redacted]. At that time, the [redacted] confirmed that Resident #95 had not had his/her scheduled [redacted] on those scheduled days, and that she was responsible for ensuring that [redacted] were done.

On 5/29/24 at 9:19 AM, the surveyor interviewed CNA #3 who stated that she was not always able to give the residents [redacted] on their assigned [redacted] days because sometimes she had "too

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F 677	Continued From page 20 many residents and it gets too hectic." On 5/29/24 at 10:13 AM, the [redacted] in the presence of the [redacted], and [redacted] acknowledged [redacted] should be given on the resident's assigned days. The [redacted] further stated if the [redacted] was not given on the assigned day, it should be given the following day. 7. On 5/20/24 at 11:41 AM, Resident #94's Representative (RR #1) informed the surveyor that Resident #94 had not received their scheduled [redacted] on Friday [redacted], and that their last shower was on Tuesday [redacted]. RR #1 further stated that Resident #94's [redacted] were scheduled weekly for Tuesdays and Fridays, but that the facility was often short-staffed, and he/she was "lucky" if they even get one [redacted] per week. The surveyor reviewed the medical record of Resident Resident #94. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included [redacted], NJ Ex Order 26.4(b)(1), and a NJ Ex Order 26.4(b)(1). A review of the most recent quarterly 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 NJ Ex Order 26.4(b)(1) [redacted]. A further review revealed the resident required [redacted] from staff for [redacted] and [redacted] and was frequently	F 677		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

(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
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NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)

A review of the ICCP included a focus area dated NJ Ex Order 26.4(b), that the resident was at risk for NJ Ex Or related to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Interventions included to NJ Ex Order 26.4 ASAP after NJ Ex Order 26. or NJ Ex Order 2 ; keep NJ Ex Order 26.4(b) clean and NJ Ex O keep NJ Ex Or clean and NJ Ex O An additional focus area included ADL self-care performance with interventions that included to provide NJ Ex Or with NJ Ex Order 26.4 NJ Ex Order 26.4(b)(, NJ Ex Order 26.4(b and NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b) from NJ Ex Order 2 and NJ Ex Order 26.4(b)(1).

On 5/28/24 at 10:10 AM, the surveyor interviewed CNA #5 who informed the surveyor that the resident's NJ Ex Order 26.4 days were listed on each of the CNA's assignments. CNA #5 further stated that when a NJ Ex Order 26. was done, the CNAs signed the NJ Ex Order 26.4b1 NJ Ex Order 26.4 Sheet which was kept in a notebook.

On 5/28/24 at 10:15 AM, the surveyor interviewed the U.S. FOIA (b) (6) who provided the surveyor with copies of Resident #94's Shower Sheets. A review of the NJ Ex Order 26. sheets revealed that Resident #94 had not received their scheduled NJ Ex Order 26.4(b) on NJ Ex , NJ Ex , NJ Ex Or , NJ Ex Orde or NJ Ex Order 26.4(. At that time, the U.S. FOIA (b) (6) confirmed that Resident #94 had not had his/her scheduled NJ Ex Order 26.4(on those days and stated that she was responsible for ensuring that NJ Ex Order 26.4(were done.

On 5/29/24 at 9:19 AM, the surveyor interviewed CNA #3 who stated that she was not always able to give the residents NJ Ex Order 26.4(on their assigned NJ Ex Order 26. days because sometimes she had "too

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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many residents and it gets too hectic."

On 5/29/24 at 10:13 AM, the [redacted] in the presence of the [redacted] U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged [redacted] should be given on the resident's assigned days. The [redacted] further stated if the [redacted] were not given on the assigned day, they should be given the following day.

8. On 5/20/24 at 11:06 AM, the surveyor observed Resident #109 in bed and observed his/her [redacted] were [redacted], and [redacted] with a NJ Ex Order 26.4(b)(1).

On 5/22/24 at 7:32 AM, the surveyor accompanied by the [redacted] entered Resident #109's room. The [redacted] confirmed the [redacted] were NJ Ex Order 26.4(b)(1). The [redacted] stated that the nurses were responsible for [redacted] and the CNAs were responsible for cleaning them and that they should be checked and cleaned daily.

The surveyor reviewed the medical record for Resident #109.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included [redacted] and NJ Ex Order 26.4(b)(1).

A review of the most recent comprehensive MDS dated [redacted], reflected the resident had [redacted] and required [redacted] for [redacted] and [redacted]

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A review of the ICCP included a focus area dated [redacted], that the resident was at risk for [redacted] due to a NJ Ex Order 26.4(b)(1). Interventions included to keep [redacted] and [redacted] and NJ Ex Order 26.4(b)(1) ASAP after [redacted] or NJ Ex Order 26.4(b)(1).

On 5/29/24 at 10:13 AM, the [redacted] in the presence of the [redacted] U.S. FOIA (b) (6), and U.S. FOIA (b) (6) stated that [redacted] care was part of grooming and that CNAs should be checking, [redacted] and cleaning the residents [redacted] The [redacted] further stated that if a resident had a diagnoses of [redacted] the CNAs should not [redacted], but should still [redacted] and clean them.

9. On 5/21/24 at 11:45 AM, the surveyor observed Resident #16 seated in a [redacted] chair and observed the resident had a [redacted] in place to their [redacted]. The surveyor observed that Resident #16's [redacted] on both their [redacted] and [redacted] were NJ Ex Order 26.4(b)(1).

The surveyor reviewed the medical record of Resident #16.

A review of the Admission Record face sheet, reflected that the resident was admitted to the facility with diagnoses that included [redacted] NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

A review of the most recent comprehensive MDS dated [redacted], reflected the resident had [redacted] and was [redacted] on staff

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F 677	Continued From page 24 for [redacted] and [redacted] A review of the ICCP included a focus area dated [redacted], that included ADLs with interventions that included to provide [redacted] with [redacted], [redacted] and [redacted] On 5/23/24 at 12:51 PM, the surveyor interviewed the [redacted] assigned to Resident #16's care who acknowledged that the resident's [redacted] were [redacted] and stated that both the nurse and CNA were responsibility for providing [redacted] care for the residents. On 5/29/24 at 10:13 AM, the [redacted] in the presence of the [redacted], and [redacted] stated that [redacted] was part of grooming and that CNAs should be checking, [redacted] and cleaning the residents [redacted]. The [redacted] further stated that if a resident had a diagnoses of [redacted] the CNAs should not [redacted], but should still [redacted] and clean them. A review of the facility's "Activities of Daily Living (ADLs) Supporting" policy dated revised March 2018, included resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living ... NJAC 8:39-27.1(a), 27.2(h)	F 677		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		7/10/24

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F 698	Continued From page 25 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 observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure a residents who received [NJ Ex Order 26.4(b)(1)] were being assessed in accordance to their NJ Ex Order 26.4(b)(1) and professional standards of practice every shift and b.) ensure a resident who received [NJ Ex Order 26.4(b)(1)] services was care planned for. This deficient practice was identified for 2 of 2 residents reviewed for [NJ Ex Order 26.4(b)(1)] (Resident #62 and #84), and was evidenced by the following: 1. On 5/21/24 at 11:39 AM, the surveyor observed Resident #62 in their room watching television. The resident informed the surveyor that he/she received [NJ Ex Order 26.4] treatments ([NJ Ex Order 26.4(b)(1)]). The surveyor reviewed the medical record for Resident #62. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included NJ Ex Order 26.4(b)(1), [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)(1)]. A review of the Order Summary Report included the following physician's orders (PO): A PO dated [NJ Ex Order 26.4], for [NJ Ex Order 26.4] three times a	F 698	F698 Dialysis Resident affected by deficient practice: The facility failed to a.) ensure residents who received [NJ Ex Order 26.4(b)(1)] were being assessed in accordance to their NJ Ex Order 26.4(b)(1) and professional standards of practice every shift and b.) ensure a resident who received [NJ Ex Order 26.4(b)(1)] services was care planned for. This deficient practice was identified for 2 of 2 residents reviewed for [NJ Ex Order 26.4b1] (Resident #62 and #84). Identify those individuals who could be affected by the deficient practice: All residents who receive hemodialysis have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: All residents who receive hemodialysis were monitored for any adverse effects with none noted. A facility wide audit was completed by the Director of Nursing on 5/28/2024 to ensure that all residents who receive hemodialysis are assessed in accordance to their hemodialysis access site and professional standards of practice every shift with physician orders in place. Also, ensure that all residents who receive hemodialysis have an existing and	

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F 698	Continued From page 26 week on Mondays, Wednesdays, and Fridays. A PO dated [NJ Ex Order 26.4], to monitor [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)] for signs and symptoms of [NJ Ex Order 26.4(b)]. A PO dated [NJ Ex Order 26.4], to [NJ Ex Order 26.4(b)(1)] on [NJ Ex Order 26] every shift for [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)]. A review of the comprehensive care plan did not include a focus area with interventions for dialysis. On 5/23/24 at 10:45 AM, the surveyor interviewed the [U.S. FOIA (b) (6)]) who stated the resident was on [NJ Ex Order 26.4] and was cleared to use the [NJ Ex Order 26.4(b)] as an [NJ Ex Order 26.4(b)(1)] two to three weeks ago. The [U.S. FOIA] stated the resident also had a [NJ Ex Order 26.4(b)(1)] in their [NJ Ex Order] that was covered. The [U.S. FOIA] stated there were no assessments that she needed to do for the [NJ Ex] or [NJ Ex Order 26.4(b)(1)] no dressings that were done either. The resident had a communication record that went with him/her to [NJ Ex Order 26.4] and [NJ Ex Order 26.4] obtained [NJ Ex] and [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] stated the [U.S. FOIA (b) (6)]) completed the care plans. On 5/23/24 at 10:54 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated for a resident who went to [NJ Ex Order 26.4(b)] the facility obtained vital signs prior to leaving and the [NJ Ex Order 26.4] center obtained [NJ Ex] and [NJ Ex Order 26.4(b)(1)]. The facility used a communication record to communicate with the [NJ Ex Order 26.4] center anything that occurred at [NJ Ex Order 26.4(b)] or anything that	F 698	updated care plan to meet their needs. Residents #62 and #84 were assessed, physician orders were obtained and care plans were completed to ensure proper assessment, monitoring, and follow-up as required. All Licensed Nurses were reeducated by the Director of Nursing on 6/4/2024 on the following facility policies: Hemodialysis Access Care and Care Plans, Comprehensive Person-Centered to ensure compliance with the requirement. Measures or systematic changes to ensure that the deficiencies will not recur: The Director of Nursing, Assistant Director of Nursing or Designee will conduct audits of 2 resident charts who are receiving Hemodialysis to ensure that they are assessed according to physician orders, based on the facility policies and standards of practice every shift. The audits will be conducted weekly for 4 weeks, then bi-weekly for 2 months. The Director of Nursing, Assistant Director of Nursing or Designee will conduct 2 audits weekly of resident charts who are receiving Hemodialysis for 4 weeks, then bi-weekly for 2 months to ensure that residents who are receiving hemodialysis have a comprehensive, person-centered care plan in place related to hemodialysis. Results of all audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessment for further action.	

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the facility needed to follow-up on. The U.S. FOIA (b) (6) stated if a resident had a NJ Ex Order 26.4(b)(1) professional standards of practice was to monitor the NJ Ex Or keep clean and NJ Ex O and make sure no NJ Ex Order 26 or NJ Ex Order 26.4(b every shift. The U.S. FOIA (b) (6) stated professional standards of practice for an NJ Ex Order 26.4(b) was to check NJ Ex Ord and NJ Ex Or every shift; which was an assessment done by feeling their NJ Ex Order 26.4(b)(for NJ Ex Order 26.4(b)(1) that can be done with fingers or stethoscope done every shift to make sure functioning, no NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b If there was any issues, the nurse notified the physician immediately. The U.S. FOIA (b) (6) confirmed there should be a physician's order to check NJ Ex Ord and NJ Ex Or as well as a care plan.

At that time, the U.S. FOIA (b) (6) review Resident #62's medical record, and confirmed the resident was using the NJ Ex Order 26.4(b) since NJ Ex Order 2, and there was no physician's order to check NJ Ex Ord and NJ Ex Or every shift as well as no care plan. The U.S. FOIA (b) (6) stated there should also be an NJ Ex O precaution order; no NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) from that NJ Ex Ord

On 5/23/24 at 11:22 AM, the U.S. FOIA (b) (6) in the presence of the surveyor checked Resident #62's NJ Ex Ord and NJ Ex Ord which the U.S. FOIA (b) (6) confirmed there was one. The U.S. FOIA (b) (6) stated as long as the resident had an NJ Ex Order 26.4(b)(whether it was in use or not, the nurses should have checked for NJ Ex Ord and NJ Ex Or every shift.

The surveyor continued to review the resident's medical record. A review of the Progress Notes since NJ Exec Orde did not include a Nurse's Note every shift that the bruit and thrill was monitored.

On 5/24/24 at 8:12 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated if a

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resident had a NJ Ex Order 26.4(b)(1) there should be orders to check it, and if the resident had an NJ Ex [redacted] there should be orders to check NJ Ex Ord and NJ Ex Ord every shift. The U.S. FOIA acknowledged that she was aware there was no physician's order to check the resident's NJ Ex Ord and NJ Ex Ord every shift as well as NJ Ex Order 26.4 care plan prior to surveyor inquiry.

On 5/29/24 at 10:13 AM, the U.S. FOIA in the presence of the U.S. FOIA (b) (6)), U.S. FOIA (b) (6), U.S. FOIA (b) (6), and survey team stated Resident #62 had an NJ Ex Order 26.4(b) created on NJ Ex Order 26.4, that was cleared for use on NJ Ex Order 2. The U.S. FOIA confirmed that the nurse should be assessing for NJ Ex Ord and NJ Ex Or every shift regardless if the NJ Ex Order 26.4(b) was in use or not.

2. The surveyor reviewed the medical record for Resident #84.

A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1)).

A review of the Order Summary Report included the following physician's Orders (PO):

A PO dated NJ Ex Order 26.4, for NJ Ex Order 26.4 three times a week on Mondays, Wednesdays, and Fridays.
A PO dated NJ Ex Order 26.4(, monitor NJ Ex Order 26.4(b)(1)) for NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b) NJ Ex Orde NJ Ex Orde greater than NJ Ex Order 26.4(b)(1), signs and symptoms of NJ Ex Order 26.4(post surgery every shift.
A PO dated NJ Ex Order 26.4 , for no NJ Ex Order 26.4(b)(1) or NJ Ex Or [redacted] to the NJ Ex Order 26.4(b)(every shift.

A review of the comprehensive care plan included

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a focus area dated [redacted] for I need [redacted] due to [redacted]; no [redacted] to [redacted]; I require [redacted] related to [redacted] and [redacted]). Interventions included to not [redacted] or [redacted] in [redacted] with [redacted] I may need encouragement to go to scheduled [redacted] appointments on Mondays, Wednesdays, Fridays; monitor for signs and symptoms of [redacted] to [redacted] monitor for [redacted] and apply [redacted] as needed; monitor for [redacted]; monitor for signs and symptoms of [redacted]; monitor for signs and symptoms of [redacted]; monitor labs; obtain vital signs and [redacted]

On 5/23/24 at 10:54 AM, the surveyor interviewed the [redacted] who stated for a resident who went to [redacted] the professional standards of practice for an [redacted] was to check [redacted] and [redacted] every shift; which was an assessment done by feeling their [redacted] for [redacted] that can be done with fingers or stethoscope done every shift to make sure functioning, no [redacted] or [redacted] If there was any issues, the nurse notified the physician immediately. The [redacted] confirmed there should be a physician's order to check [redacted] and [redacted] every shift.

On 5/23/24 at 11:25 AM, the surveyor re-interviewed the [redacted] who confirmed Resident #84 did not have a PO to check [redacted] and [redacted] every shift, and she was putting one in now. The [redacted] stated the resident's [redacted] was revised multiple times, and the resident had developed [redacted]. The [redacted] center is looking into a [redacted] at this point.

The surveyor continued to review the resident's

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medical record. A review of the Progress Notes since [NJ Ex Order 2] did not include a Nurse's Note every shift that the [NJ Ex Ord] and [NJ Ex Or] was monitored.

On 5/24/24 at 8:12 AM, the surveyor interviewed the [U.S. FOIA] who stated if a resident had an [NJ Ex] , there should be orders to check [NJ Ex Ord] and [NJ Ex Or] every shift. The [U.S. FOIA] acknowledged that she was aware there was no physician's order to check the resident's [NJ Ex Ord] and [NJ Ex Or] every shift prior to surveyor inquiry.

On 5/29/24 at 10:13 AM, the [U.S. FOIA] in the presence of the [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] , and survey team stated Resident #84 had a PO to check [NJ Ex Ord] and [NJ Ex Or] until they were re-admitted from a hospitalization on [NJ Ex Order 26.4], and the PO was never put in. The [U.S. FOIA] stated from [NJ Ex Order 26.4] through [NJ Ex Order 26.4], there was twelve documented times on the [NJ Ex Order 26.4] communication record that [NJ Ex Ord] and [NJ Ex Or] was checked, as well as the Progress Notes contained twenty-seven times nurses documented [NJ Ex Ord] and [NJ Ex Or] was checked from [NJ Ex Order 26.4] to [NJ Ex Order 26.4]. The [U.S. FOIA] acknowledged that [NJ Ex Ord] and [NJ Ex Or] needed to be checked every shift, every day.

A review of the facility's "Hemodialysis Access Care" policy dated reviewed January 2024, included...care involves the primary goal of preventing infection and maintaining patency of the catheter (preventing clots); to prevent infection and/or clotting: keep access site clean and dry at all times; do not use the access site to take blood samples, administer intravenous fluids or give injections; needle access for hemodialysis should be rotated; check for signs of infection (warmth, redness, tenderness, or edema) at the access site when performing care and at regular

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F 698	Continued From page 31 intervals; do not access arm to take blood pressure; advise resident not to sleep on, wear tight jewelry or lift heavy objects with access arm; check color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals; and check patency of the site at regular intervals. Palpate the site to feel the "thrill", or use a stethoscope to hear the "whoosh" or bruit" of the blood flow through the access site...the general medical nurse should document in the resident's medical record every shift as follows: location of the catheter; condition of the dressing (interventions if needed); if dialysis was done during shift; any part of report from dialysis nurse post-dialysis being given; observations post-dialysis. A review of the facility's "Care Plans, Comprehensive Person-Centered" policy dated reviewed January 2024, included a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident...the comprehensive, person-centered care plan will:...describe the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being... NJAC 8:39-27.1 (a)	F 698		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must-	F 711		7/10/24

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	315453	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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F 711	Continued From page 32 §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 161027 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that the resident's primary physician wrote and signed their Physician's Progress Notes at the time of each visit. This deficient practice was identified for 1 of 3 residents reviewed for closed records (Resident #147) , and evidenced by the following: The surveyor reviewed the closed medical record for Resident #147. A review of the Admission Record face sheet (an admission summary) reflected that Resident #147 was admitted to the facility with diagnosis that included, but not limited to, NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1) [redacted]. A review of the Physician's Progress Notes (PPN) in the electronic medical record (eMR) revealed	F 711	F711 Physician Visits - Review Care/Notes/Order. Resident affected by deficient practice: " The facility failed to ensure that the resident's primary physician wrote and signed their Physician's Progress Notes at the time of each visit. This deficient practice was identified for 1 of 3 residents reviewed for closed records (Resident #147).Resident #147 was discharged to home from the facility on [redacted] with NJ Exec Order 26.4b1. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: " All residents charts were reviewed and updated physicians progress notes.	

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F 711	Continued From page 33 the following had a "LATE ENTRY", a designation which indicated the notes were not written on the effective date (Date of service): 1. PPN with an effective date of [redacted], but with a created date of [redacted]. 2. PPN with an effective date of [redacted], but with a created date of [redacted]. 3. PPN with an effective date of [redacted], but with a created date of [redacted] at 12:33:29. 4. PPN with an effective date of [redacted], but with a created date of [redacted] at 12:32:56. 5. PPN with an effective date of [redacted], but with a created date of [redacted] at 12:32:20. On 5/28/24 at 10:16 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who reviewed the resident's eMR and confirmed the above entries were not entered at the time of visit. On 5/28/24 at 1:58 PM, in the presence of the survey team, the surveyor informed the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6), and U.S. FOIA (b) (6) the concern that physician progress notes were entered days after the patient visit. On 5/29/24 at 11:23 AM, the U.S. FOIA (b in the presence of the U.S. FOIA (b) (U.S. FOIA (b) (6), and U.S. FOIA (b) (6) confirmed that the physician did not document and sign the PPN at the time of the physician visit. A review of the facility's "Physician Visits" policy, last reviewed January 2024, included [...] 5. The Attending Physician must perform relevant tasks at the time of each visit, including a review of the	F 711	" The U.S. FOIA (b) (6) and NJ Ex Order 26.4(b)(1) were reeducated by the Regional Licensed Nursing Home Administrator on 6/4/2024 on the facility policy titled Physician Visits. All physicians were reeducated on 6/4/2024 by the Licensed Nursing Home Administrator and provided a copy of the facility policy titled Physician Visits. Measures or systematic changes to ensure that the deficiencies will not reoccur: " The Licensed Nursing Home Administrator, Director of Nursing or Designee will conduct 4 audits on residents charts for timely completed physician s progress notes weekly for 4 weeks, then 2x monthly for 2 months to ensure that primary physicians wrote and signed their Physician's Progress Notes at the time of each visit as required. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 711	Continued From page 34 resident's total program of care and appropriate documentation. NJAC 8:39-23.2(b)	F 711		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 161027 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face-to-face visits and wrote progress notes at least every 30 days. This deficient practice was	F 712	F712 Physician Visits Frequency/Timeliness/Alt NPP Resident affected by deficient practice: The facility failed to ensure that the physician responsible for supervising the care of residents conducted face-to-face visits and wrote progress notes at least every 30 days. This deficient practice was	7/10/24

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F 712	Continued From page 35 identified for 1 of 3 residents reviewed for closed records (Resident #151) and was evidenced by the following: The surveyor reviewed the closed medical record for Resident #151. A review of the Admission Record face sheet (an admission summary) reflected that Resident #151 was admitted to the facility with diagnosis that included, but not limited to NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)). According to the Admission Record, Resident #151 was in the facility for a total of NJ Ex Upon review of Resident #151's electronic medical record (eMR), the surveyor located U.S. FOIA (b) (6)) handwritten NJ Ex Order 26.4(assessments; however, the surveyor was not able to locate any physician assessments for Resident #151. On 5/28/24 at 10:16 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that it was the facility's expectation that a physician examined all residents upon admission and every 30 days. The U.S. FOIA (b) reviewed the resident's eMR and confirmed that there was no physician assessment entries. On 5/28/24 at 1:58 PM, in the presence of the survey team, the surveyor informed the U.S. FOIA (b) (6) , U.S. FOIA (b) (6) , U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) the concern that Resident #151 did not have any documented physician visits or admission assessment.	F 712	identified for 1 of 3 residents reviewed for closed records (Resident #151). Resident #151 has been discharged from the facility. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: All resident charts were reviewed and updated to ensure physician visits are occurring at appropriate intervals according to the facility policy titled Physician Visits. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were reeducated by the Regional Licensed Nursing Home Administrator on 6/4/2024 on the facility policy titled Physician Visits. All physicians were reeducated by the Licensed Nursing Home Administrator on 6/4/2024 and provided a copy of the facility policy titled Physician Visits. Measures or systematic changes to ensure that the deficiencies will not recur: The Licensed Nursing Home Administrator, Director of Nursing or Designee will conduct audits of 2 resident charts weekly for 4 weeks, then audits of 2 resident charts bi-weekly for 2 months to ensure that primary physicians conducted and documented face-to-face visits in accordance with the facility s	

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F 712	Continued From page 36 On 5/29/24 at 11:123 AM, the U.S. FOIA confirmed that there were no physician assessments on record. A review of the facility's "Physician Visits" policy, last reviewed January 2024, included [...] 2. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter [...].	F 712	Physician Visit policy. Results of all audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessment for further action.	
F 725 SS=E	NJAC 8:39-11.2(b) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		7/10/24

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F 725	Continued From page 37 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 157735; 160630; 164199; 170619; 172027 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure sufficient and competent staff were available to a.) provide appropriate [NJ Ex Order 26.4(b)(1)] care to [NJ Ex Order 26.4b1] residents for 5 of 8 residents (Resident # 94, #16, #8, #109, and #137) and b.) ensure residents received [NJ Ex Order 26.4(b] as scheduled for 2 of 2 residents (Resident #95 and #94) reviewed for sufficient staffing, and was evidenced by the following: Refer to F677 1. On 5/20/24 at 11:41 AM, the surveyor observed Resident #94 in bed with their eyes open, [NJ Ex Or] . The Resident's Representative (RR #1) informed the surveyor that Resident #94 had not received care that morning which included [NJ Ex Order 26.4(b)(1)] care, and that they were still [NJ Ex Order 26.4] from last night. At that time, Resident #94 nodded in agreement. On 5/20/24 at 11:52 AM, the surveyor found Resident #94's Certified Nursing Assistant (CNA #1) who confirmed she was the resident's aide for the day, and stated she had provided [NJ Ex Order 26.4(b)(1)] care earlier that shift. The surveyor accompanied by CNA #1, entered Resident #94's	F 725	F725 Sufficient Nursing Staff Residents affected by deficient practice: The facility failed to ensure sufficient and competent staff were available to a.) provide appropriate [NJ Ex Order 26.4(b)(1)] care to [NJ Ex Order 26.4b1] residents for 5 of 8 residents (Resident # 94, #16, #8, #109, and #137) and b.) ensure residents received [NJ Ex Order 26.4(b] as scheduled for 2 of 2 residents (Resident #95 and #94). Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: All residents were monitored for any adverse effects with none noted. A facility-wide assessment was done to ensure that all patients had their most recent scheduled [NJ Ex Order 26.] and appropriate [NJ Ex Order 26.4(b)(1)] care was completed. Residents #94, #16, #8, #109, and #137 were provided with the appropriate [NJ Ex Order 26.4(b)(1)] care and residents #95 and #94 received [NJ Ex Order 26.4(b] per their preferences and scheduled [NJ Ex Order 26.] days. The U.S. FOIA (b) (6), U.S. FOIA (b) (6)	

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F 725	Continued From page 38 room and pulled back the resident's blanket which revealed the resident was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1), and the surveyor observed a NJ Ex Order 26.4(b)(1). CNA #1 stated she had not provided care yet for that resident, she was mistaken. CNA #1 further stated that she had ten residents on her assignment that day and had not provided care. Review of the CNA assignment sheet revealed the unit had a census of 51 Residents with five assigned aides. CNA #1 had an assignment of ten residents on that shift. On 5/22/24 at 7:23 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that NJ Ex Order 26.4(b)(1) rounds should be completed every two hours. On 5/24/24 at 10:17 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who confirmed that NJ Ex Order 26.4(b)(1) care should be done every two hours on the day shift. On 5/29/24 at 10:13 AM, the U.S. FOIA in the presence of the U.S. FOIA (b) U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b)(1) care should be provided every two hours. 2. On 5/22/24 at 7:45 AM, the surveyor did NJ Ex Order 26.4(b)(1) rounds with the U.S. FOIA (b) (6) on the NJ Exec Order 26.4b1 Unit and observed Resident #16 in bed with an NJ Ex Order 26.4(b)(1). The surveyor and U.S. FOIA (b) (6) observed a NJ Ex Order 26.4(b)(1). At that time, the U.S. FOIA (b) (6) confirmed that the NJ Ex Or should have been changed every two hours, and that the resident's NJ Ex Or could not have been changed at 5:00 AM.	F 725	U.S. FOIA (b) (6), and U.S. FOIA (b) (6) were reeducated by the Regional Licensed Nursing Home Administrator on 6/4/2024 on the facility's Staffing policy. All Certified Nursing Assistants, Licensed Practical Nurses, and Registered Nurses were reeducated on 6/4/2024 by the Director of Nursing on the facility policy Activities of Daily Living (ADLs) Supporting. The facility will continue to utilize Agency staff from multiple companies to fill the open shifts. The facility implemented new and more competitive wages for Certified Nurses Aides and Licensed Nurses. The facility implemented an expedited and robust onboarding process. The facility will continue to participate in a bi-weekly recruitment call to review open positions and recruitment tactics. The facility will continue to monitor and resolve concerns communicated by patients and families to ensure that the patients needs are met. Measures or systematic changes to ensure that the deficiencies will not recur: The Director of Nursing/Designee will interview 2 residents weekly for 4 weeks, then twice monthly for 2 months to ensure that residents are receiving incontinence care at appropriate intervals and showers as scheduled. Administrator/Designee will conduct 2 audits weekly for 4 weeks, then twice monthly for 2 months to ensure the facility is staffed in accordance with the facility	

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F 725	Continued From page 39 On 5/23/24 at 9:24 AM, the surveyor attempted a phone interview with the CNA #2 who was assigned to Resident #16 on the NJ Ex Order 26.4 11:00 PM to 7:00 AM (11-7) shift with no answer. Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #2 had an assignment of 18 residents on that shift. On 5/24/24 at 10:17 AM, the surveyor interviewed the U.S. FOIA who confirmed that NJ Ex Order 26.4(b)(1) care should be provided every two hours on the day shift and twice on the night shift. The first NJ Ex Order 26.4(b)(1) rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. On 5/29/24 at 10:13 AM, the U.S. FOIA in the presence of the U.S. FOIA (b) U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b)(1) care should be provided every two hours. 3. On 5/20/24 at 12:13 PM, the surveyor observed Resident #8 in their room seated in a wheelchair. The Resident's Representative (RR #2) stated that on Saturday he/she observed the resident's clothing was NJ Ex Order 26.4(b)(1), and observed a NJ Ex Order 26.4(b)(1) under their wheelchair. On 5/21/24 at 10:44 AM, the surveyor observed Resident #8 in his/her room seated in a wheelchair with CNA #3 in the room. The surveyor observed a NJ Ex Order 26.4(b)(1) in the room. CNA #3 acknowledged the NJ Ex Ord and stated that the resident's NJ Ex Order 26.4(b)(1), NJ Ex O	F 725	policy Staffing to accommodate resident needs. Results of all interviews/audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessment for further action.	

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F 725	Continued From page 40 NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) were all NJ Ex Order 26.4(b)(1) and stated, "not sure what night shift does." CNA #3 confirmed that was her first NJ Ex Order 26.4(b)(1) care provided for Resident #8 for that day. On 5/22/24 at 7:41 AM, during NJ Ex Order 26.4(b)(1) rounds, the surveyor observed the resident with an NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) the NJ Ex Order 26.4(b)(1). At that time, the surveyor interviewed the U.S. FOIA (b) (6) who stated that NJ Ex Order 26.4(b)(1) inside an NJ Ex Order 26.4(b)(1) was unacceptable, and that it could cause NJ Ex Order 26.4(b)(1). On 5/23/23 at 9:30 AM, the surveyor attempted a phone interview with CNA #4 who was assigned to Resident #8 on the NJ Ex Order 26.4(11-7 shift with no answer. Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift. On 5/24/24 at 10:17 AM, the surveyor interviewed the U.S. FOIA who confirmed that NJ Ex Order 26.4(b)(1) care should be provided every two hours on the day shift and twice on the night shift. The first NJ Ex Order 26.4(b)(1) rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. On 5/29/24 at 10:13 AM, the U.S. FOIA in the presence of the U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b)(1) care should be provided every two hours and that NJ Ex Order 26.4(b)(1) should not be placed inside NJ Ex Order 26.4(b)(1) unless requested by the family or the resident. The U.S. FOIA acknowledged	F 725		

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F 725	Continued From page 41	F 725		

that NJ Ex Order 26.4(b)(1) inside an NJ Ex Order 26.4(b)(1) increased the chance of NJ Ex Order 26.4(b)(1).

4. On 5/22/24 at 7:32 AM the surveyor did NJ Ex Order 26.4(b)(1) rounds with the U.S. FOIA (b) (6) on the NJ Exec Order 26.4b1 Unit and observed Resident #109 in bed wearing an NJ Ex Order 26.4(b)(1) with a NJ Ex O inside their NJ Ex Order 26.4(b)(1).

On the same date at 7:36 AM, the surveyor and U.S. FOIA (b) (6) observed Resident #137 in bed with an NJ Ex Order 26.4(b)(1) and a NJ Ex Order 26.4(b)(1) inside the NJ Ex Orde

On 5/23/23 at 9:30 AM, the surveyor attempted to interview CNA #4 who was assigned to Resident #109 and #137 on the NJ Ex Order 26.4 11-7 shift with no answer.

Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift which included Resident #109 and #137.

On 5/24/24 at 10:17 AM, the surveyor interviewed the U.S. FOIA who confirmed that NJ Ex Order 26.4(b)(1) care should be provided every two hours on the day shift and twice on the night shift. The first NJ Ex Order 26.4(b)(1) rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM.

On 5/29/24 at 10:13 AM, the U.S. FOIA in the presence of the U.S. FOIA (b) U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b)(1) care should be provided every two hours and that NJ Ex Order 26.4(b)(1) should not be placed inside NJ Ex Order 26.4(b)(1) unless requested by the

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COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

(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
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family or the resident. The [U.S. FOIA] acknowledged that inserting [NJ Ex Order 26.4(b)(1)] inside an [NJ Ex Order 26.4(b)(1)] increased the chance of [NJ Ex Order 26.4(b)(1)].

5. On 5/20/24 at 11:41 AM, the surveyor interviewed Resident #95 who stated that he/she did not receive their scheduled [NJ Ex Order 26.] on Friday [NJ Ex Order 26.], and that their last [NJ Ex Order 26.] was on Tuesday [NJ Ex Order 26.4(b)] Resident #95 stated that their [redacted] were scheduled weekly for Tuesdays and Fridays, but that the facility was often short-staffed, and he/she was "lucky" if they even received one [NJ Ex Order 26.] per week.

On 5/28/24 at 10:10 AM, the surveyor interviewed CNA #5 who informed the surveyor that resident [redacted] days were listed on each of the CNA's assignments. CNA #5 further stated that when a [redacted] was done, the CNAs signed the [NJ Exec Order 26.4b1] [NJ Ex Order 26.] Sheet which was kept in a notebook.

A review of the [NJ Ex Order 26.4b1] [NJ Ex Order 26.] Sheet revealed that Resident #95 had not received their [NJ Ex Order 26.] on [NJ Ex Order 26.].

On 5/28/24 at 10:15 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] who confirmed that the [NJ Ex Order 26.] sheet had not been signed indicating that Resident #95 had not received their [NJ Ex Order 26.] The [U.S. FOIA (b) (6)] further stated that she was responsible for ensuring all residents received [NJ Ex Or] [NJ Ex Order 26.4b] on the assigned [NJ Ex Order 26.] days.

On 5/29/24 at 9:19 AM, the surveyor interviewed CNA #3 who stated that she was not always able to give the residents [NJ Ex Order 26.4(] on their assigned [NJ Ex Order 26.] days because sometimes she had "too

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many residents and it gets too hectic."

On 5/29/24 at 10:13 AM, the U.S. FOIA in the presence of the U.S. FOIA (b) (6), and U.S. FOIA (b) (6) acknowledged NJ Ex Order 26.4(b) should be given on the resident's assigned days. The U.S. FOIA further stated if the NJ Ex Order 26. was not given on the assigned day, it should be given the following day.

6. On 5/20/24 at 11:41 AM, Resident #94's representative (RR #1) informed the surveyor that the resident had not received their scheduled NJ Ex Order 26. on Friday NJ Ex Order 26.4(b), and that their last NJ Ex Order 26. was on Tuesday NJ Ex Order 26.4. RR #1 further stated that Resident #94's NJ Ex Order 26.4(b) were scheduled weekly for Tuesdays and Fridays, but that the facility was often short-staffed, and he/she was "lucky" if they even received one NJ Ex Order 26. per week.

On 5/28/24 at 10:10 AM, the surveyor interviewed CNA #5 who informed the surveyor that the resident NJ Ex Order 26. days were listed on each of the CNA's assignments. CNA #5 further stated that when a NJ Ex Order 26. was done, the CNAs signed the NJ Ex Order 26.4b1 NJ Ex Order 26.4 Sheet which was kept in a notebook.

A review of the Applewood NJ Ex Order 26.4 Sheet revealed that Resident #94 had not received their NJ Ex Order 26. on NJ Ex Order 26.4.

On 5/28/24 at 10:15 AM, the surveyor interviewed the U.S. FOIA (b) (6) who confirmed that the NJ Ex Order 26. sheet for Resident #94 had not been signed indicating that Resident #94 had not received their NJ Ex Order 26.4 The U.S. FOIA (b) (6) further stated that she was responsible for ensuring all residents received

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F 725	Continued From page 44 their [NJ Ex Order 26.4(b)] on their assigned [NJ Ex Order 26.4(b)] days. On 5/29/24 at 9:19 AM, the surveyor interviewed CNA #3 who stated that she was not always able to give residents [NJ Ex Order 26.4(b)] on their assigned [NJ Ex Order 26.4(b)] days because sometimes she had "too many residents and it gets too hectic." On 5/29/24 at 10:13 AM, the [U.S. FOIA (b) (6)] in the presence of the [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)], and [U.S. FOIA (b) (6)] acknowledged [NJ Ex Order 26.4(b)] should be given on the resident's assigned days. The [U.S. FOIA (b) (6)] further stated if the [NJ Ex Order 26.4(b)] were not given on the assigned day, they should be given the following day. A review of the facility's "Staffing" policy updated September 2023, included our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care and facility assessment...staffing numbers and skills requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care... A review of the facility's "Activities of Daily Living (ADLs) Supporting" policy dated revised March 2018, included resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living...	F 725		
F 812 SS=E	NJAC 8:39-5.1(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		7/10/24

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F 812	Continued From page 45 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to a.) store potentially hazardous foods to prevent food-borne illness; b.) maintain multiuse food-contact surface cutting board in a manner to prevent microbial growth; c.) ensure washed cookware was dried in a manner to prevent microbial growth; d.) maintain storage areas in a sanitary manner. This deficient practice was evidenced by the following: On 5/21/24 at 8:40 AM, the surveyor toured the kitchen with the U.S. FOIA (b) (6)) and observed the following: 1. In front on the walk-in freezer unit, stored	F 812	F812-Food Procurement Residents affected by deficient practice: The facility failed to a.) store potentially hazardous foods to prevent food-borne illness; b.) maintain multiuse food-contact surface cutting board in a manner to prevent microbial growth; c.) ensure washed cookware was dried in a manner to prevent microbial growth; d.) maintain storage areas in a sanitary manner. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected.	

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F 812	Continued From page 46 directly on the floor, five stacks of twenty-four cases in total of ice cream cups, and a stack of frozen vegetables with a box of oriental blend vegetables directly on the floor. The U.S. FOIA stated the frozen items were just delivered and the U.S. FOIA (b) (6) was labeling the boxes before transferring them into the freezer. The U.S. FOIA acknowledged food should not be stored or come in direct contact with the floor. 2. In the walk-in freezer, the vinyl strip curtains located in the entrance to the freezer, two curtain strips were missing in the middle of the doorway. These curtains protect the inside of the freezer from outside dust particles as well as keep the cold air from escaping the freezer when the door was opened. The freezer was currently at 25 degrees Fahrenheit. The U.S. FOIA stated the temperature had increased from the door being opened for the deliveries. 3. On the shelves in the walk-in freezer, the boxes were covered in a thick layer of frost which included the following items that the U.S. FOIA identified for the surveyor: a case of beef hamburger patties; three liquid coffee containers; broccoli florets; broccoli spears; health shakes; cheese blintz; and stuffed cabbage. The U.S. FOIA confirmed frost and ice should not be covering the food, and was caused by the door being opened for deliveries. 4. In the walk-in freezer, the condenser unit had a build-up of ice, and the top shelf under the condenser unit contained rods of ice approximately four to six inches in length. The U.S. FOIA acknowledged the unit and shelves should not have ice buildup.	F 812	What corrective action will be accomplished for those residents affected by the deficient practice: All residents were monitored for any adverse effects with none noted. The five stacks of twenty-four cases in total of ice cream cups, and a stack of frozen vegetables with a box of oriental blend vegetables were immediately picked up from the floor, properly labeled, and stored properly in the walk-in freezer on 5/21/2024. The two curtain strips in the middle of the doorway were replaced on 6/3/2024 to ensure that the walk-in freezer maintains the proper temperature. The layer of frost that covered the identified boxes was removed on 5/21/2024 with no further issues. The built-up ice on the condenser and the rods of ice on the top shelf under the condenser unit were removed on 5/21/2024 with no further issues. The built-up ice on the insider of the ice cream chest was removed on 5/21/2024 with no further issues. The dented six-pound four-ounce can of cut sweet potatoes was removed from the active inventory area on 5/21/2024. An audit of the dry storage area was completed on 5/21/2024 and ensured that there were no other dented cans in the active inventory area.	

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F 812	Continued From page 47 5. The ice cream chest had a build up of ice on the inside. 6. In dry storage ,one six-pound four-ounce can of cut sweet potatoes dented was in active inventory. 7. On a storage shelf, one large brown cutting board deeply pitted with black discoloration; one large light blue cutting board pitted and yellowish discoloration in grooves; one large brown cutting board pitted; one large yellow cutting board pitted and discolored black; two large red cutting boards pitted; and one large green cutting board pitted with yellow discoloration in the grooves. The U.S. FOIA stated cutting boards were replaced every quarter or six months and acknowledged those cutting boards needed to be replaced. The U.S. FOIA stated the grooves could cause bacterial growth. 8. On the storage rack, two four-inch half pans were wet nesting and five four-inch plastic half pans were wet nesting. One of the plastic half pans had brownish debris in it and was missing a corner of the plastic. The U.S. FOIA confirmed the broken plastic half pan should not be in use, and pans should not be wet nested. On 5/22/24 at 8:30 AM, the U.S. FOIA (b) (6) stated the walk-in freezer repair company was at the facility yesterday afternoon who replaced the motor on the freezer unit which was now operating properly. On 5/29/24 at 10:13 AM, the U.S. FOIA (b) in the presence of the U.S. FOIA (b) (6)), U.S. FOIA (b) (6), and U.S. FOIA (b) (6), acknowledged the surveyor's concerns.	F 812	All cutting boards identified as pitted, with black and yellowish discoloration were taken out of service and replaced with new cutting boards on 5/21/2024. The two four-inch half pans and the five four-inch plastic half pans that were wet nesting were removed, washed, and properly placed to dry on 5/21/2024. The plastic half pan with brownish debris and missing a corner of the plastic was discarded on 5/21/2024. All dietary staff were re-educated on 6/4/2024 by the Licensed Nursing Home Administrator on the following policies: Dish Washing and Pot Washing, Kitchen Equipment, Receiving and Inspecting Guidelines, Cutting Board, Dented Can. Measures or systemic changes to ensure that the deficiencies will not recur: The Dining Service Director/Designee will conduct one audit weekly for 4 weeks, then 2x monthly for 2 months. The audits will ensure that all items are properly stored and not directly on the floor, no ice buildup is present in the walk-in freezer, fridge or ice cream chest, no dented cans are in the active inventory area, all cutting boards are in good condition to be used, no wet nesting is present, and no debris or damage is present on any pans. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 812	Continued From page 48 A review of the facility provided undated "Dish Washing and Pot Washing" policy included...all items must be air dried. This will allow the sanitizer to break down any biofilms and avoid nesting. Note: nesting is when two or more wet pans are placed together. This causes moisture to become trapped and does not allow it to dry. This can cause bacterial growth and contaminate clean pans... A review of the facility provided undated "Kitchen Equipment" policy included all kitchen equipment is inspected daily by food service director, by maintenance during rounds and with recommendations from outside service companies during visits... A review of the facility provided undated "Receiving and Inspecting Guidelines" policy included...product placement...store items away from the walls and at least six inches off the floor... A review of the undated facility provided policy "Cutting Board Policy" included...replace when needed. A review of the undated facility provided policy "Dented Can Policy" included...the Food Service Director or designee will spot check all cans upon delivery to ensure there are no dents, bulges, or punctures; all cans identified to not be in good condition will be moved to the designated dented can area... NJAC 8:39-17.2(g)	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly	F 814		7/10/24

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F 814	Continued From page 49 CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to properly dispose and maintain cardboard waste in dumpster areas. This deficient practice was identified for 1 of 3 garbage dumpsters, and was evidenced by the following: During a tour of the kitchen on 5/21/24 at 8:40 AM, the surveyor accompanied by the U.S. FOIA (b) [redacted]) observed the facility's garbage compactor and cardboard dumpster. The surveyor observed the cardboard dumpster to be overfilled with intact cardboard boxes that prevented the lid from closing. The area surrounding the dumpster had piles of intact cardboxes surrounding the side walk of the dumpster area approximately four to five feet in height, as well as intact cardboard boxes in the fire zone of the facility parking lot. The U.S. FOIA stated the cardboard dumpster was disposed of twice a week, and today was a delivery day. The U.S. FOIA acknowledged the cardboard boxes should not be around the dumpster area, that it was not being maintained in a sanitary manner. On 5/28/24 at 8:53 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated the garbage compactor was collected every other Tuesday, and cardboard was collected every Monday and Friday. The U.S. FO stated he did not see the cardboard dumpster area until after the surveyor observed it with the U.S. FOIA (b and staff had	F 814	F814 □ Dispose Garbage Properly Residents affected by deficient practice: The facility failed to properly dispose and maintain cardboard waste in dumpster areas. This deficient practice was identified for 1 of 3 garbage dumpsters. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: All residents were monitored for any adverse effects with none noted. The cardboard dumpster was emptied to allow the lid to be completely closed, and all cardboard surrounding the dumpster, the sidewalk, and in the fire zone was properly cleaned and discarded on 5/21/2024. All dietary, housekeeping, and maintenance staff were re-educated on 6/4/2024 by the Licensed Nursing Home Administrator on the following policy: Garbage and Trash Disposal to ensure that facility properly dispose and maintain cardboard waste in the dumpster areas. Measures or systematic changes to	

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F 814	Continued From page 50 already cleaned the area. At that time, the surveyor showed the U.S. FO a picture of the area at the time of observation, and the U.S. FO confirmed the condition of the area was unacceptable. The U.S. FO stated the boxes that were identified still intact were both from the nursing department as well as dietary, and the boxes should have been broken down and not left intact. On 5/29/24 at 10:13 AM, the U.S. FOIA (b) (6) in the presence of the U.S. FOIA (b) (6)), U.S. FOIA (b) (6), U.S. FOIA (b) (6), and survey team stated it was the facility's policy if the cardboard dumpster was filled, the cardboard boxes could be stored next to the dumpster. At that time, the surveyor showed the U.S. FOIA (b) a picture of the dumpster area at the time of observation and asked if the area was maintained in acceptable condition, and the U.S. FOIA (b) did not respond. A review of the undated facility provided "Garbage and Trash Disposal Policy" included the Dining Services Director coordinates with the Directors of Maintenance and Housekeeping to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris...cardboard and other recycling dumpsters should be properly maintained: dumpster door or lid must be closed at all times when not in use; all staff is responsible to breakdown cardboard boxes after each use; and all boxes should be placed in the recycling dumpster flattened as to not take up additional space. If cardboard dumpster is full, stack cardboard on concrete next to dumpster until emptied; area around dumpster should remain clean and free from refuse; report any dumpster or trash compactor issues to maintenance immediately.	F 814	ensure that the deficiencies will not recur: The Dining Service Director/Designee will conduct daily audits for 7 days, then two audits weekly for 3 weeks, then two audits 2x monthly for 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly Meetings over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 814	Continued From page 51	F 814		
F 880 SS=E	NJAC 8:39-19.3(a); 19.7(a)(b) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following 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	F 880		7/10/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 52 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain infection control standards of practice and procedures to a.) ensure appropriate hand hygiene was performed during lunch meal in 2 of 5 dining areas; b.)	F 880	F880 - Infection Prevention & Control Residents affected by deficient practice: " The facility failed to maintain infection control standards of practice and	

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	315453	A. BUILDING _____ B. WING _____	C 05/29/2024

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F 880	Continued From page 53 ensure appropriate infection control practices were maintained for 1 of 1 Resident (Resident #16) observed during [redacted] treatments and c.) follow appropriate hand hygiene practices during resident care for 1 of 7 residents (Resident #8) reviewed for Activities of Daily Living (ADLs). The evidence was as follows: 1. On 5/20/24 from 11:35 AM to 11:48 AM, the surveyor observed dining in the Meadows Unit. Prior to handing out lunch trays, the Unit Manager/Licensed Practical Nurse (UM/LPN #1) was observed placing alcohol based hand rub (ABHR) on top of the food truck that contained resident lunch trays. During tray pass, a Licensed Practical Nurse (LPN #1) and Activity Aide (AA #1) were each observed being handed a tray by UM/LPN #1. LPN #1 and AA #1 were observed placing the tray in front their designated resident. LPN #1 and AA #1 proceeded to uncover each resident's plate, use the resident's utensils to cut food, then immediately proceeded to obtain another resident's tray without performing hand hygiene. During the course of the meal observation, staff was not observed performing hand hygiene in between each tray pass. On 5/20/24 from 11:52 AM to 12:21 PM, the surveyor observed dining in the Main Dining Room prior to meal service, hand hygiene was not performed to the residents seated in the room. Meals were delivered to the residents by "waitress style" to each table. The surveyor observed Restorative Aide (RA #1) assist a resident and used their utensils to cut their meal, and then proceeded to pour coffee and open	F 880	procedures to a.) ensure appropriate hand hygiene was performed during lunch meal in 2 of 5 dining areas; b.) ensure appropriate infection control practices were maintained for 1 of 1 Resident (Resident #16) observed during [redacted] treatments and c.) follow appropriate hand hygiene practices during resident care for 1 of 7 residents (Resident #8) reviewed for Activities of Daily Living (ADLs). Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: " All residents who consumed meals in the dining areas were monitored for any adverse effects with none noted. " Residents #16 and #8 were monitored for any adverse effects with none noted " Licensed Practical Nurse (LPN #1), Activity Aide (AA #1), Restorative Aide (RA #1) and (CNA#3) were re-educated and completed a Hand Hygiene Competency by the Director of Nursing on 5/29/2024 " Licensed Practical Nurse (LPN #2) was reeducated by the Director of Nursing on 5/29/2024 on proper disinfecting of supplies and tools, such as scissors and markers post completion of skin treatments and to only bring in the amounts supplies required for the treatment. " All Certified Nursing Assistants, Licensed Practical Nurses, and	

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F 880	Continued From page 54 sweetener packages. RA #1 continued to additional residents performing the same process of cutting residents' meals and serving coffee without performing hand hygiene. On 5/20/24 at 12:27 PM, the surveyor interviewed AA #1 who stated that hand hygiene was required "as needed" between every couple residents or deemed necessary. When asked if hand hygiene was required after tray contact AA #1 responded, not necessarily. On 5/20/24 at 12:34 PM, the surveyor interviewed LPN #1 who confirmed that hand hygiene was required after every couple residents and was not necessary after every tray contact. On 5/20/24 at 12:39 PM, the surveyor interviewed UM/LPN #1 who stated that there was no expectation of hand hygiene in between residents since the staff was not touching food. When asked if hand sanitation should be expected after touching resident utensils, UM/LPN #1 stated that they were not sure. On 5/20/24 at 12:49 PM, the surveyor interviewed RA #1 regarding hand hygiene who explained hand sanitation was to be completed as necessary or when hands were visibly dirty. RA #1 confirmed it was not expected between every resident contact. When asked how hand sanitation was completed with the residents, RA #1 explained that it would be completed by floor staff before the residents are brought to the dining room. RA #1 confirmed that hand hygiene was not completed with residents in the dining room. On 5/21/24 at 10:32 AM, the surveyor	F 880	Registered Nurses were reeducated on 6/4/2024 by the Director of Nursing on facility policy for Wound Care clinical protocol, Hand Hygiene and the importance of disinfecting the surface to be used, maintaining a clean field, providing a protective barrier, and washing and drying hands thoroughly. Measures or systemic changes to ensure that the deficiencies will not reoccur: " The DON/Unit Manger/Designee will conduct audits of 4 nurses for competency of wound care procedure and 4 staff members for Hand Hygiene. Audits will be completed weekly X 4 weeks then monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly Meetings over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 880	Continued From page 55	F 880		

re-interviewed UM/LPN #1 who stated that they spoke with the U.S. FOIA (b) (6) and was instructed that hand hygiene was required between each resident when food was cut up and in between tray pass. UM/LPN #1 confirmed that hand hygiene was not performed the day prior in between each tray pass and after assisting residents with their meal set up.

On 5/28/34 at 10:16 PM, the surveyor interviewed U.S. FOIA (b) (6) who stated that it was expected that staff was to perform hand hygiene in between any interaction with lunch trays that included use of resident utensils for meal set up. When asked regarding the hand sanitation of residents in the main dining room, the U.S. FOIA (b) (6) confirmed that handwipes were to be handed out by the person "overseeing" the dining room prior to meal service.

On 5/29/24 at 10:13 AM, the U.S. FOIA (b) (6)), in the presence of the U.S. FOIA (b) (U.S. FOIA (b) (6) , and U.S. FOIA (b) (6) confirmed handwashing was expected between passing out trays and cutting up food.

A review of the facility's "Hand Washing" policy last revised January 2024, included..2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors...7. Use an alcohol based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...o. before and after eating or handling food; before and after assisting a resident with meals...

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2. On 5/22/24 at 7:45 AM, the surveyor observed Resident #16 in bed.

The surveyor reviewed the medical record of Resident #16.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1))NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1), reflected the resident had NJ Ex Order 26.4(b)(1) and was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A further review revealed the resident had NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)

A review of the NJ Ex Order 26.4(b)(1) Physician Order Summary (POS) which was transcribed onto the Treatment Administration Record (TAR) included a physician's order dated NJ Ex Order 26.4(b)(1), to cleanse the NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), apply NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), with NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)); NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) daily and when needed (prn); NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) and apply NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1), cover with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) daily and prn; NJ Ex Order 26.4(b)(1) with

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F 880	Continued From page 57 NJ Ex Order 26.4(b)(1) for 3-5 minutes, apply NJ Ex Order 2 and NJ Ex Order 26.4(b)(1), cover with NJ Ex Order 26.4(b) and NJ Ex Orde with NJ Ex Order 26.4(b)(1) daily and prn. On 5/22/24 at 10:55 AM, the surveyor observed LPN #2 perform a treatment to Resident #16's NJ Ex Order 26.4 with UM/LPN #2 who assisted with the resident's NJ Ex Order 26.4(b)(1) The surveyor observed the following: LPN #2 disinfected the over-bed table (OBT) with sanitizing wipes and applied a clean barrier. LPN #2 then assembled the needed supplies from the treatment cart and placed them on the OBT in the resident's room. Among the supplies were a bottle of NJ Ex Order 26.4(b)(1), a tube o NJ Ex Order 26 , NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Ord , scissors, and a marker. The LPN put small amounts of the NJ Ex Order 26.4(b)(1) into two separate medicine cups. LPN #2 provided the treatment for Resident #16's NJ Ex Order 26.4 according to the physician's orders, and after the treatment, the LPN put the scissors she used to remove the NJ Ex Order 26.4(b)(1) and the pen she used to initial and date the NJ Ex Order 26.4(b)(into her pocket without first sanitizing them. The LPN then placed the tube of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) back into the treatment cart without sanitizing them. The LPN did not sanitize the overbed table after she completed the treatment. On 5/22/24 at 11:49 AM, the surveyor interviewed LPN #2 regarding the NJ Ex Order 26 treatment observation who acknowledged that she should not have brought the tube of NJ Ex Order 26.4(b)(1) and bottle of NJ Ex Order 26.4(b)(1) into the resident's room;	F 880		

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F 880	Continued From page 58	F 880		

she should have taken only what she needed. She further confirmed that she should not have put the contaminated scissors and marker into her pocket but rather should have sanitized them and then returned them to the treatment cart.

On 5/24/24, at 11:47 AM, the surveyor interviewed the U.S. FOIA who confirmed that anything used in a resident's room should be disinfected before being placed in the treatment cart.

On 5/24/24 at 12:06 PM, the surveyor interviewed the U.S. FOIA (b) (6) who confirmed that LPN #2 should not have brought the tube of NJ Ex Order 2 and bottle of NJ Ex Order 26.4(b)(1) into the room, but only the amounts needed for the treatment. The U.S. FOIA (b) (6) further stated that the scissors and marker should have been disinfected and returned to the treatment.

A review of the facility's "Clinical Competency Validation Wound Dressing-Aseptic" checklist reflected discarding materials and PPE according to infection control policy.

3. On 5/23/24 at 10:32 AM, the surveyor observed Resident #8 in bed and observed CNA #3 providing ADL care. The surveyor observed that CNA #3 handled Resident #8's NJ Ex Order 26.4(b)(1) , then wet her hands with water, applied soap, and immediately placed her hands under the stream of running water.

On 5/23/24 at 12:30 PM, the surveyor interviewed CNA #3, who confirmed that she should have washed her hands outside the stream of water for 20 seconds.

On 5/24/24 at 11:47 AM, the surveyor interviewed

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F 880	Continued From page 59 the U.S. FOIA (b) who confirmed that staff should lather their hands with soap for 20 seconds outside the stream of water. On 5/24/24 at 12:06 PM, the surveyor interviewed the U.S. FOIA (b) (6), who confirmed that staff should apply soap to their hands and lather for 30 seconds before placing them under running water. A review of the facility's "Hand Washing" policy last revised January 2024, included 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors...7. Use an alcohol-based hand rub containing at least 62% alcohol or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...before and after eating or handling food; before and after assisting a resident...Washing Hands 1. vigorously lather hands with soap and rub them together, creating friction for a minimum of 20 seconds... NJAC 8:39-19.4 (a) 27.1 (a)	F 880		

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S 000	Initial Comments 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 deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 157735; 160630; 164199; 170619; 172027 Part A 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 63 out of 63 day shifts and 3 of 63 overnight shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	S560 Mandatory Access to Care Residents affected by deficient practice: The facility failed to maintain the required minimum direct cares staff-to-resident rations as mandated by the State of New Jersey. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: All residents were monitored for any	7/19/24

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S 560	Continued From page 1 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: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. During entrance conference on 5/20/24 at 9:54 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) how the facility's staff was, and the LNHA stated that staffing was good; that the facility utilized Agency Staff as needed. At that time, the surveyor requested the Nurse Staffing Report to be completed for the following weeks: 12/25/22 to 12/31/22; 1/8/23 to 1/14/23; 5/7/23 to 5/13/23; 5/14/23 to 5/20/23; 8/27/23 to 9/2/23; 1/21/24 to 1/27/24; 2/18/24 to 2/24/24; 5/5/24 to 5/11/24; and 5/12/24 to 5/18/24. The surveyor reviewed the facility completed Nurse Staffing Reports which revealed the following:	S 560	adverse effects with none noted. Director of Nursing, Human Resources Director, and Staffing, Coordinator were re-educated on the minimum staffing requirements on 6/4/2024 by the Administrator. The facility has implemented a competitive market rate for nurses and certified nursing aides. The facility continues to utilize online recruitment with immediate interviews and contingency offers. The facility implemented an expediated but robust onboarding process. The facility will use agency staff as needed to meet staffing needs. Facility will continue to participate in a bi-weekly recruitment call to review open positions, recruitment tactics, and changes to improve outcomes. All these efforts will provide an opportunity to meet the required staffing minimums. Measures or systemic changes to ensure that the deficiencies will not recur: Administrator/Designee will conduct 2 audits weekly for 4 weeks, then twice monthly for 2 months to ensure adequate staff is scheduled to accommodate resident needs. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessment for further action. S560- Part B Residents affected by deficient practice: The facility failed to notify the Clearing	

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S 560	Continued From page 2 1. For the week of Complaint staffing from 12/25/22 to 12/31/22, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: 12/25/22 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. 12/26/22 had 11 CNAs for 132 residents on the day shift, required at least 16 CNAs. 12/27/22 had 11 CNAs for 132 residents on the day shift, required at least 16 CNAs. 12/28/22 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. 12/29/22 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. 12/30/22 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. 12/31/22 had 11 CNAs for 132 residents on the day shift, required at least 16 CNAs. 2. For the week of Complaint staffing from 1/8/23 to 1/14/23, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: 1/8/23 had 8 CNAs for 132 residents on the day shift, required at least 16 CNAs. 1/9/23 had 10 CNAs for 132 residents on the day shift, required at least 16 CNAs. 1/10/23 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs. 1/11/23 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. 1/12/23 had 15 CNAs for 129 residents on the day shift, required at least 16 CNAs. 1/13/23 had 13 CNAs for 129 residents on the day shift, required at least 16 CNAs. 1/14/23 had 14 CNAs for 129 residents on the day shift, required at least 16 CNAs.	S 560	House Coordinator of a Certified Nursing Aide (CNA) who was NJ Ex Order 26.4b1 of their services after the aide was discovered NJ Ex Order 26.4b1 resident's room on duty NJ Ex Order 26.4b1 as mandated by the State of New Jersey. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: The Clearing House Coordinator was notified on 7/16/2024. All residents were monitored for any adverse effects with none noted. The facility will immediately report every termination of any involved staff member, if discovered sleeping on duty, impaired, or under the influence of a substance, as mandated by the State of New Jersey to the Clearing House Coordinator. The Human Resources Director, Director of Nursing, and Licensed Nursing Home Administrator were reeducated on 6/4/2024 by the Regional Administrator on the requirements of reporting and investigating allegations of neglect and on the following facility policies: Abuse, Neglect, Exploitation and Misappropriation Prevention Program and Substance Abuse in the Workplace. Measures or systemic changes to ensure that the deficiencies will not recur:	

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	656003	A. BUILDING: _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 3. For the two weeks of Complaint staffing from 5/7/23 to 5/20/23, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: 5/7/23 had 14 CNAs for 161 residents on the day shift, required at least 20 CNAs. 5/8/23 had 15 CNAs for 161 residents on the day shift, required at least 20 CNAs. 5/9/23 had 16 CNAs for 159 residents on the day shift, required at least 20 CNAs. 5/10/23 had 14 CNAs for 158 residents on the day shift, required at least 20 CNAs. 5/11/23 had 14 CNAs for 158 residents on the day shift, required at least 20 CNAs. 5/12/23 had 13 CNAs for 158 residents on the day shift, required at least 20 CNAs. 5/13/23 had 8 CNAs for 158 residents on the day shift, required at least 20 CNAs. 5/14/23 had 10 CNAs for 154 residents on the day shift, required at least 19 CNAs. 5/15/23 had 14 CNAs for 154 residents on the day shift, required at least 19 CNAs. 5/16/23 had 14 CNAs for 154 residents on the day shift, required at least 19 CNAs. 5/17/23 had 13 CNAs for 154 residents on the day shift, required at least 19 CNAs. 5/18/23 had 17 CNAs for 153 residents on the day shift, required at least 19 CNAs. 5/19/23 had 17 CNAs for 151 residents on the day shift, required at least 19 CNAs. 5/20/23 had 17 CNAs for 151 residents on the day shift, required at least 19 CNAs. 4. For the week of Complaint staffing from 8/27/23 to 9/2/23, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:	S 560	Human Resources Director/Designee to conduct audits of employee files upon termination to ensure that any allegations of neglect are reported and investigated as required and the Clearing House Coordinator is notified as mandated by the State of New Jersey. Audits will be completed weekly for 4 weeks, then twice monthly for 2 months. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 4 8/27/23 had 7 CNAs for 144 residents on the day shift, required at least 18 CNAs. 8/28/23 had 11 CNAs for 144 residents on the day shift, required at least 18 CNAs. 8/29/23 had 13 CNAs for 144 residents on the day shift, required at least 18 CNAs. 8/30/23 had 13 CNAs for 144 residents on the day shift, required at least 18 CNAs. 8/31/23 had 11 CNAs for 144 residents on the day shift, required at least 18 CNAs. 9/1/23 had 14 CNAs for 146 residents on the day shift, required at least 18 CNAs. 9/2/23 had 15 CNAs for 146 residents on the day shift, required at least 18 CNAs. 5. For the week of Complaint staffing from 1/21/24 to 1/27/24, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: 1/21/24 had 11 CNAs for 147 residents on the day shift, required at least 18 CNAs. 1/22/24 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs. 1/23/24 had 14 CNAs for 147 residents on the day shift, required at least 18 CNAs. 1/24/24 had 14 CNAs for 147 residents on the day shift, required at least 18 CNAs. 1/25/24 had 16 CNAs for 147 residents on the day shift, required at least 18 CNAs. 1/26/24 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. 1/27/24 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. 6. For the week of Complaint staffing from 2/18/24 to 2/24/24, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7	S 560		

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COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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S 560	Continued From page 5 overnight shifts as follows: 2/18/24 had 10 CNAs for 150 residents on the day shift, required at least 19 CNAs. 2/18/24 had 10 total staff for 150 residents on the overnight shift, required at least 11 total staff. 2/19/24 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs. 2/20/24 had 14 CNAs for 150 residents on the day shift, required at least 19 CNAs. 2/21/24 had 12 CNAs for 150 residents on the day shift, required at least 19 CNAs. 2/22/24 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs. 2/23/24 had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. 2/24/24 had 14 CNAs for 145 residents on the day shift, required at least 18 CNAs. 7. For the two weeks of staffing prior to survey from 5/5/24 to 5/18/24, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows: 5/5/24 had 8 CNAs for 156 residents on the day shift, required at least 19 CNAs. 5/6/24 had 15 CNAs for 155 residents on the day shift, required at least 19 CNAs. 5/7/24 had 14 CNAs for 155 residents on the day shift, required at least 19 CNAs. 5/8/24 had 15 CNAs for 155 residents on the day shift, required at least 19 CNAs. 5/9/24 had 14 CNAs for 155 residents on the day shift, required at least 19 CNAs. 5/10/24 had 13 CNAs for 155 residents on the day shift, required at least 19 CNAs. 5/11/24 had 16 CNAs for 155 residents on the day shift, required at least 19 CNAs. 5/11/24 had 8 total staff for 155 residents on the	S 560		

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S 560	Continued From page 6 overnight shift, required at least 11 total staff. 5/12/24 had 14 CNAs for 159 residents on the day shift, required at least 20 CNAs. 5/13/24 had 15 CNAs for 159 residents on the day shift, required at least 20 CNAs. 5/14/24 had 14 CNAs for 159 residents on the day shift, required at least 20 CNAs. 5/15/24 had 15 CNAs for 159 residents on the day shift, required at least 20 CNAs. 5/16/24 had 14 CNAs for 159 residents on the day shift, required at least 20 CNAs. 5/17/24 had 13 CNAs for 159 residents on the day shift, required at least 20 CNAs. 5/18/24 had 16 CNAs for 159 residents on the day shift, required at least 20 CNAs. 5/18/24 had 8 total staff for 159 residents on the overnight shift, required at least 11 total staff. On 5/28/24 at 10:58 AM, the surveyor interviewed the Staffing Coordinator who stated she scheduled CNAs based on the census; scheduling one CNA to every eight residents during the day shift; one CNA for every ten residents during the evening shift; and one CNA for every twelve residents during the overnight shift. The Staffing Coordinator stated that she used Agency Staff for nurses and CNAs as needed, but the sometimes they did no show up to the facility as scheduled. The Staffing Coordinator acknowledged the facility did not always meet the required staffing. Part B Based on interview and review of pertinent facility documents, it was determined that the facility failed to notify the Clearing House Coordinator of a Certified Nursing Aide (CNA) who was	S 560		

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S 560	Continued From page 7 [redacted] of their services after the aide was discovered [redacted] in a [redacted] on duty [redacted] and [redacted] of a [redacted] as mandated by the State of New Jersey. This deficient practice was identified for 1 of 6 terminated employee files reviewed and the findings were as followed: Reference: New Jersey Administrative Code Title 13 Law and Public Safety Chapter 45E Health Care Professional Reporting Responsibility. Subchapter 3: 13:45E-3.1 Notification to the Clearing House Coordinator by a Health Care Entity a) Except as provided in (c) below, a health care entity shall file a report with the Clearing House Coordinator concerning a health care professional who is employed by, under contract to render professional services to, has clinical privileges granted by that health care entity, or who provides such services pursuant to an agreement with a health care services firm or staffing registry if: 1) For reasons relating to health care professional's impairment, incompetency or professional misconduct, which incompetency or professional misconduct relates adversely to patient care or safety, the health care entity: i) Summarily or temporarily revokes or suspends or permanently reduces, suspends or revokes the health care professional's full or partial clinical privileges or practice; ii) Removes the health care professional from the list of eligible employees of health services firm or	S 560		

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S 560	Continued From page 8 staffing registry; iii) Discharges the health care professional from the staff of the health care entity; or iv) Terminates or rescinds a contract with the health care professional to render professional services: During entrance conference on 5/20/24 at 9:54 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to provide the survey team with a list of all employees hired since last standard survey who were still employed by the facility or NJ Ex Order 26.4b1 The surveyor requested the facility provide the reason for NJ Ex Order 26.4b1 On 5/24/24 at 9:35 AM, the surveyor requested from the DON ten employee files including personal and medical from the provided list. A review of CNA #1's files revealed the following: The employee was hired on NJ Ex Order 26.4(b, with an Employee NJ Ex Order 26.4b1 form dated effective NJ Ex Order 26.4, with a NJ Ex Order 26.4b1 summary for "staff was observed to be NJ Ex Order 26.4(b)(1) of a NJ Ex Order 26.4(b)(1) According to her, she stated she took too much of her NJ Ex Order 26.4(b)(1)] and never brought in a NJ Ex Order 26.4 A review of the New Employee NJ Ex Order 26.4(b Examination signed by CNA #1 on NJ Ex Order 26.4(b, indicated for list of medical conditions was left blank, and the list of all medications you are currently using and indication of use did not include NJ Ex Order 26.4(b)(1).	S 560		

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S 560	Continued From page 9 On 5/28/24 at 11:40 AM, the surveyor interviewed the DON regarding CNA #1's NJ Ex Order 26.4b1, and the DON stated she received a phone call from the US FOIA (b)(6) that aide was NJ Ex Order 26.4(b)(1) and she was NJ Ex Order 26.4(b)(1) in a NJ Ex Order 26.4(b)(1). Staff woke CNA #1 up and she stated she was NJ Ex Ord and went back to work, but was found NJ Ex Order 26.4(b) so she was sent home. The DON stated she spoke to CNA #1 the next day who stated she said had been NJ Ex Order 26.4(b)(1), and she took too much of her NJ Ex Order 26.4(b)(1). The DON requested a copy of the NJ Ex Order 26.4(b)(1) and the CNA stated she would provide the NJ Ex Order 26.4(b)(1), but she never did. The DON stated when the facility suspected an employee being NJ Ex Order, they were sent out to the hospital for NJ Ex Order 26.4b1, but the facility did not NJ Ex Order 26.4b1 CNA #1 because the aide stated she had a NJ Ex Order 26.4(b)(1) that was never confirmed and the CNA could not provide the name of the NJ Ex Order 26.4(b)(1). The DON stated CNA #1 never brought in the NJ Ex Order 26.4(b)(1) so she never worked again, and the DON confirmed she did not report the CNA's condition to any agency or licensing boards since the CNA was "just NJ Ex Order 26.4 The DON stated she was unsure who in the state would be notified. At that time, the surveyor requested a copy of CNA #1's assignment sheet for the day, as well as their time card, and the facility's policy regarding an employee NJ Ex Order 26.4(b)(1). A review of CNA #1's time card revealed the last day she worked was NJ Ex Order 26.4(b) from 4:49 PM until 10:45 PM. A review of the CNA Assignment sheet for the 3:00 PM to 11:00 PM shift on NJ Ex Order 26.4(b), revealed CNA #1 was assigned fourteen residents, which	S 560		

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S 560	Continued From page 10	S 560		

included twelve residents who needed assistance with transferring from bed to chair or chair to bed with five of the residents using a [NJ Ex Order] lift (an assistive device that uses a sling to lift the resident in the air to be transferred between a bed and chair).

On 5/28/24 at 2:05 PM, the DON in the presence of the LNHA, Assistant Director of Nursing (ADON), Regional LNHA, Regional Nurse, and survey team, stated the incident with CNA #1 occurred on [NJ Ex Order 26.4(b)], and the CNA returned to the facility the next day to speak with the DON. The DON stated CNA #1 stated she was on an NJ Ex Order 26.4(b)(1) that the aide was unsure of the name, and never provided the [NJ Ex Order 26.4(b)(1)] The DON could still not speak to who the incident should be reported to.

On 5/29/24 at 10:13 AM, the LNHA in the presence of the DON, Regional LNHA, Regional Nurse, and survey team stated the facility would report the incident to the New Jersey Department of Health who would direct the facility to report the incident to anyone further.

A review of the facility's "Substance Abuse in the Workplace" policy dated 2020, included the facility is committed to ensuring a drug and alcohol-free workplace in order to maintain the safety of its residents...being under the influence of alcohol or illegal drugs while at the facility poses a serious health and safety risk to all residents...staff may not present in the Facility...conduct any Facility-sanctioned task while impaired on a substance...this policy does not prohibit appropriate use of over the counter and legal prescription medication when used to treat a disability...nothing in this policy is meant to prohibit the appropriate use of over-the-counter

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S 560	Continued From page 11 medication or other medication that can legally be prescribed under both federal and state law, to the extent that it does not impair a staff member's job performance or safety or safety of others...a violation of this policy is subject to disciplinary action, up to and including termination of employment. The policy does not include to notify the Clearing House of the impairment. A review of the facility's "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" dated reviewed January 2024, included protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not limited to: a. facility staff...identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property; investigate and report any allegations within the timeframes required by federal requirements...	S 560		
S1695	8:39-25.2(e) Mandatory Nurse Staffing (e) A registered professional nurse shall be on duty at all times in facilities with more than 150 licensed beds. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documents, it was determined that the facility failed to have a Registered Nurse on duty at all times. This deficient practice was identified for	S1695	S1695 Mandatory Access to Care Residents affected by deficient practice: The facility failed to have a Registered	7/10/24

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S1695	Continued From page 12 12 out of 42 shifts reviewed, and was evidenced by the following: During entrance conference on 5/20/24 at 9:54 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) how the facility's staff was, and the LNHA stated that staffing was good; that the facility utilized agency staff as needed. At that time, the surveyor requested the Nurse Staffing Report to be completed for the following weeks: 5/5/24 to 5/11/24; and 5/12/24 to 5/18/24. The surveyor reviewed the facility completed Nurse Staffing Reports which revealed the following: During the week of 5/5/24 to 5/11/24, there was no Registered Nurse (RN) on during the day shift (7:00 AM to 3:00 PM) on 5/11/24, and during the night shift (11:00 PM to 7:00 AM) on 5/6/24; 5/7/24; 5/8/24; and 5/11/24. During the week of 5/12/24 to 5/18/24, there was no RN during the day shift on 5/12/24 and 5/18/24, and during the night shift on 5/12/24, 5/13/24, 5/14/24, 5/15/24, and 5/18/24. On 5/23/24 at 9:00 AM, the surveyor requested from the DON the nursing schedules from 5/5/24 to 5/18/24. A review of the nursing schedules provided confirmed there was no RN on duty for the twelve shifts during the two week period reviewed. On 5/28/24 at 10:58 AM, the surveyor interviewed the Staffing Coordinator who confirmed that a RN should be on duty at all times in the building. The facility had six RNs plus the DON, Assistant	S1695	Nurse on duty at all times. This deficient practice was identified for 12 out of 42 shifts reviewed. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: All residents were monitored for any adverse effects with none noted. Director of Nursing, Human Resources Director, and Staffing, Coordinator were re-educated on the Registered Nurse requirements on 6/4/2024 by the Administrator. The facility has implemented a competitive market rate for Registered Nurses. The facility continues to utilize online recruitment with immediate interviews and contingency offers. The facility implemented an expediated but robust onboarding process. The facility will use agency staff as needed to meet staffing needs. Facility will continue to participate in a bi-weekly recruitment call to review open positions, recruitment tactics, and changes to improve outcomes. All these efforts will provide an opportunity to meet the required staffing minimums. Measures or systemic changes to ensure that the deficiencies will not recur: Administrator/Designee will conduct 2 audits weekly for 4 weeks, then twice monthly for 2 months to ensure adequate	

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S1695	Continued From page 13 Director of Nursing (ADON), and the Minimum Data Set (MDS) Coordinator. The surveyor reviewed the past two weeks of staffing with the Staffing Coordinator who confirmed the facility did not always have a RN in the building. On 5/28/24 at 1:57 PM, the surveyor informed the LNHA, DON, ADON, Regional LNHA, and Regional Nurse about the above findings. No additional information was provided. A review of the facility's "Staffing" policy updated September 2023, included our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care and facility assessment...licensed nurses and certified nursing assistants are available 24 hours a day to provide direct residnet care services... The policy does not include RN's are required to be on duty at all times.	S1695	Registered Nurses are on the schedule to accommodate resident needs as required. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessment for further action.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315453 Y1	A. Building B. Wing Y2	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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	Correction	ID Prefix	F0610	Correction	ID Prefix	F0677	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.12(c)(2)-(4)	Completed	Reg. #	483.24(a)(2)	Completed
LSC		07/19/2024	LSC		07/19/2024	LSC		07/10/2024
ID Prefix	F0698	Correction	ID Prefix	F0711	Correction	ID Prefix	F0712	Correction
Reg. #	483.25(l)	Completed	Reg. #	483.30(b)(1)-(3)	Completed	Reg. #	483.30(c)(1)-(4)	Completed
LSC		07/10/2024	LSC		07/10/2024	LSC		07/10/2024
ID Prefix	F0725	Correction	ID Prefix	F0812	Correction	ID Prefix	F0814	Correction
Reg. #	483.35(a)(1)(2)	Completed	Reg. #	483.60(i)(1)(2)	Completed	Reg. #	483.60(i)(4)	Completed
LSC		07/10/2024	LSC		07/10/2024	LSC		07/10/2024
ID Prefix	F0880	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		07/10/2024	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/29/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
656003 Y1	A. Building B. Wing Y2	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 07/19/2024	ID Prefix S1695 Reg. # 8:39-25.2(e) LSC	Correction Completed 07/10/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 5/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 05/21/24. The facility was found to be in substantial compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 05/21/24 and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Complete Care at Shorrock Gardens is a one-story building constructed in 1998 and approved for construction on 11/11/96. It is composed of Type V (111) construction and has 18 smoke compartments. The facility is fully sprinklered with a dry system (with five risers). The diesel generator powers 75% of the building. The number of occupied beds was 158 out of 180.	K 000		
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	K 321		7/10/24

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

Electronically Signed | 06/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

(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 1 system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to separate hazardous areas from other parts of the facility in accordance with NFPA 101 Life Safety Code (2012 Edition), Section 8.4. This deficient practice had the potential to affect staff and any residents in the area. Findings include: An observation on 05/21/24 at 8:38 AM of the combustible storage room located in the Administration Hall by the 200 Hall revealed the	K 321	K321 Hazardous Areas - Enclosure Residents affected by deficient practice: The facility failed to separate hazardous areas from other parts of the facility in accordance with NFPA 101 Life Safety Code (2012 Edition), Section 8.4. Identify those individuals who could be affected by the deficient practice: This deficient practice had the potential to affect all staff and residents in the area.	

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	315453	A. BUILDING **01** B. WING _____	**05/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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K 321	Continued From page 2 self-closing device was missing from the door separating it from the Corridor. The room measured over 70 square feet (sq ft) in size and contained stored combustibles (paper, cardboard boxes). During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and revealed the facility was unaware a self-closing device was required on the door. NJAC 8:39-31.2(e)	K 321	What corrective action will be accomplished for those residents affected by the deficient practice: All staff and residents were monitored for any adverse effects with none noted. The self-closing device for the door separating the Administration Hall by the 200 Hall from the Corridor was installed on 5/22/2024. All other rooms in excess of 50-square feet and storing combustibles were audited for appropriate self-closing hardware. No issues were found. The Regional Director of Maintenance conducted an in-service training on 5/22/2024 to the maintenance staff on NFPA 101, Hazardous Area Enclosure, including the requirement to have self-closing hardware on all rooms in excess of 50-square feet and storing combustibles. Measures or systematic changes to ensure that the deficiencies will not reoccur: Audit will be conducted weekly for four weeks, then monthly for two months by the Maintenance Director/ Designee on all rooms in excess of 50-square feet and storing combustibles to ensure they have self-closing hardware. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	
K 331 SS=F	Interior Wall and Ceiling Finish	K 331		7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 331	Continued From page 3 CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure interior wall finishes had a flame spread rating in accordance with NFPA 101 Life Safety Code (Life Safety Code) 2012 Edition, Section 19.3.3 and 10.2. This deficient practice had the potential to affect 74 residents. Findings include: An observation on 05/21/24 at 10:22 AM revealed the corridor wall, located in the exit hallways of the 100 and 200 wings was covered with carpet having an unknown vertical flame spread rating. The wall covering was installed on the bottom half of the wall and stopped at the handrails. The wall covering was loosely attached to the wall and no longer tightly fitting. Record review on 05/21/24 on 2:00 PM of specifications were provided for a patterned carpet for use in horizontal installations, but it did not mention the flame spread rating for use in	K 331	K331 Interior Wall and Ceiling Finish Residents affected by deficient practice: The facility failed to ensure interior wall finishes had a flame spread rating in accordance with NFPA 101 Life Safety Code (Life Safety Code) 2012 Edition, Section 19.3.3 and 10.2. Identify those individuals who could be affected by the deficient practice: This deficient practice had the potential to affect all staff and residents in that area. No residents or staff were affected. What corrective action will be accomplished for those residents affected by the deficient practice: All staff and residents were monitored for any adverse effects with none noted. The interior wall finishes in the corridor wall, located in the exit hallways of the 100 and 200 wings will be treated with a	

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K 331	Continued From page 4 vertical installations and did not match the solid carpet used as a wall covering. Documentation of the flame spread rating of the carpet for use in vertical installations was requested by the surveyor on 05/21/24 at 10:22, 1:45 PM, and 2:45 PM; however, this was not provided by the facility during the survey. During an interview at the time of the observation, the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) confirmed the finding and stated the facility could not locate documentation of the flame spread rating for the carpet as a vertical installation. According to the facility, the carpet was originally installed in 1998. NJAC 8:39-31.2(e)	K 331	fire retardant coating that has Class A flame spread rating for vertical flame resistance that is tested and certified to NFPA 101 Life Safety Code 2012 Edition standards. The Maintenance Department was educated by LNHA on NFPA 101 Life Safety Code, Section 19.3.3 and 10.2. including the requirement to ensure that affixed interior wall surfaces have flame spread rating. Measures or systematic changes to ensure that the deficiencies will not reoccur: The Maintenance Director/designee will perform inspections of all corridors to ensure that affixed interior wall surfaces have proper flame spread rating once a weekly for 4 weeks then monthly for 2 months. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	
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.	K 353		7/10/24

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K 353	Continued From page 5 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all 158 residents who resided at the facility. Findings include: A review of the facility's untitled weekly sprinkler system inspections documentation provided by the facility revealed no documented evidence the dry sprinkler system's gauges were inspected prior to August 2023. Additionally, there was no documented evidence inspections were completed for any weeks in November 2023 or October of 2023. During an interview on 05/21/24 at 2:00 PM, the U.S. FOIA (b) (6) confirmed the findings and stated the facility was unable to provide documented evidence of the missing weekly inspections of the sprinkler gauges during the survey. The U.S. FOIA (b) (6) also stated the facility swapped software systems and no longer	K 353	K353 Sprinkler System Maintenance and Testing Residents affected by deficient practice: The facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). Identify those individuals who could be affected by the deficient practice: This deficient practice had the potential to affect all residents who resided at the facility. No residents were affected. What corrective action will be accomplished for those residents affected by the deficient practice: All residents were monitored for any adverse effects with none noted. The Buildings dry sprinkler systems gauges identified were inspected on 5/22/2024. No issues were found. A facility wide audit for all other dry sprinkler systems gauges was completed by the maintenance staff on 5/22/2024 to	

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K 353	Continued From page 6 had access to the documentation. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	ensure their integrity. No issues were found. The Regional Director of Maintenance conducted an in-service training on 5/22/2024 to the maintenance staff on maintaining the sprinkler system in good working order and documenting the weekly inspections for the identified areas. Measures or systematic changes to ensure that the deficiencies will not reoccur: An audit will be conducted the maintenance director/designee weekly for four weeks, then monthly for two months to ensure the sprinkler system is in good working order and the weekly inspections are documented as required. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K 372		7/10/24

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K 372	Continued From page 7 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect 158 residents. Findings include: An observation on 05/21/24 at 9:47 AM of the smoke barrier located in the Corridor by the Therapy room revealed an unsealed two-inch gap around a wire penetration above the smoke doors and ceiling. An observation on 05/21/24 at 9:56 AM of the smoke barrier located in the Corridor by Room 310 revealed a two-inch unsealed overcut around a wire penetration above the smoke doors and ceiling. An observation on 05/21/24 at 10:03 AM of the smoke barrier located in the Corridor by the Nurses' Station at the Evergreen and Meadows unit revealed a five-inch square unsealed hole in the wall above the clock and ceiling tile, left of the smoke doors. An observation on 05/21/24 at 10:11 AM of the smoke barrier located in the Corridor of the Occupational Therapy room revealed a three-inch overcut around a group of wire penetrations above the billboard and ceiling tile.	K 372	K372 Subdivision of building spaces □ Smoke barrier Residents affected by deficient practice: The facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. Identify those individuals who could be affected by the deficient practice: This deficient practice had the potential to affect all residents who reside at the facility. What corrective action will be accomplished for those residents affected by the deficient practice: All residents were monitored for any adverse effects with none noted. The unsealed two-inch gap around a wire penetration above the smoke doors and ceiling of the smoke barrier located in the Corridor by the Therapy room was repaired and closed on 5/22/2024. The two-inch unsealed overcut around a wire penetration above the smoke doors and ceiling related to the smoke barrier located in the Corridor by Room 310 was repaired and closed on 5/22/2024. The five-inch square unsealed hole in the wall above the clock and ceiling tile, left of	

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K 372	Continued From page 8 An observation on 05/21/24 at 10:34 AM of the smoke barrier located inside the Clean Utility Closet across from Room 241 revealed an eight-inch square gap in the wall above the hard ceiling as observed from above the access panel. An observation on 05/21/24 at 11:00 AM of the smoke barrier by Room 116 revealed a two-inch overcut around a wire penetration above the smoke doors and ceiling tile. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the findings and stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers. NJAC 8:39-31.1(c), 31.2(e)	K 372	the smoke doors related to the smoke barrier located in the Corridor by the Nurses' Station at the Evergreen and Meadows unit was repaired and closed on 5/22/2024. The three-inch overcut around a group of wire penetrations related to the billboard and ceiling tile smoke barrier located in the Corridor of the Occupational Therapy was repaired and closed on 5/22/2024. The eight- inch square gap in the wall above the hard ceiling as observed from above the access panel related to the smoke barrier located inside the Clean Utility Closet across from Room 241 was repaired and closed on 5/22/2024. The two-inch overcut around a wire penetration above the smoke doors and ceiling tile related to the smoke barrier by Room 116 was repaired and closed on 5/22/2024. A facility wide audit was completed by the Maintenance Director on 5/22/2024 to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. No issues were found. The Regional Director of Maintenance conducted an in-service training on 5/22/2024 to the maintenance staff on maintaining smoke barriers to ensure protection by a system or material capable of restricting the transfer of smoke and smoke barriers in accordance with the requirement.	

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K 372	Continued From page 9	K 372	Measures or systematic changes to ensure that the deficiencies will not reoccur: An audit will be conducted by the maintenance director/designee weekly for four weeks, then monthly for 2 months to ensure the ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with the requirement. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual	K 923		7/10/24

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COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 10 cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure oxygen cylinders were secured in accordance with NFPA 99 Health Care Facilities Code (2012 Edition), Chapter 11. This deficient practice had the potential to affect staff and 35 residents. Findings include: An observation on 05/21/24 at 8:38 AM of Room [redacted] revealed one oxygen E cylinder that was not secured and protected from tipping and rupture. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and stated the facility was not aware that the oxygen cylinder was not secured prior to the survey.	K 923	K 923 Gas equipment Cylinder and container storage Residents affected by deficient practice: The facility failed to ensure oxygen cylinders were secured in accordance with NFPA 99 Health Care facilities Code (2012 Edition), Chapter 11. Identify those individuals who could be affected by the deficient practice: This deficient practice had the potential to affect all staff and residents who reside at the facility. What corrective action will be accomplished for those residents affected by the deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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K 923	Continued From page 11 NJAC 8:39-31.2(e) NFPA 99	K 923	All residents and staff were monitored for any adverse effects with none noted. The one oxygen E cylinder that was not secured and protected from tipping and rupture in [redacted] was immediately placed in a base and was completely secured and protected. A facility wide audit was completed by the Maintenance Director on 5/22/2024 to ensure oxygen cylinders were secured and protected from tipping and rupture in accordance with the regulation. No issues were found. The Regional Director of Maintenance conducted an in-service training on 5/22/2024 to all facility staff on maintaining all oxygen E cylinders in all areas secured and protected as required. Measures or systematic changes to ensure that the deficiencies will not reoccur: An audit will be conducted by the maintenance director/designee weekly for four weeks, then monthly for 2 months to ensure that all oxygen E cylinders in all areas are secured and protected as required. Results of the audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315453 Y1	A. Building 01 - SHORROCK GARDENS B. Wing Y2	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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 K0321	07/10/2024	LSC K0331	07/26/2024	LSC K0353	07/10/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0372	07/10/2024	LSC K0923	07/10/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO